BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK

A STUDY OF THE INCIDENCE OF ALCOHOLISM IN THE WORLD WAR II VETERANS ADMITTED AS PATIENTS TO THE VETERANS ADMINISTRATION HOSPITAL, BEDFORD, MASSACHUSETTS, DURING THE PERIOD OF JANUARY 1, 1945 THROUGH JUNE 30, 1945.

A Thesis

Submitted by

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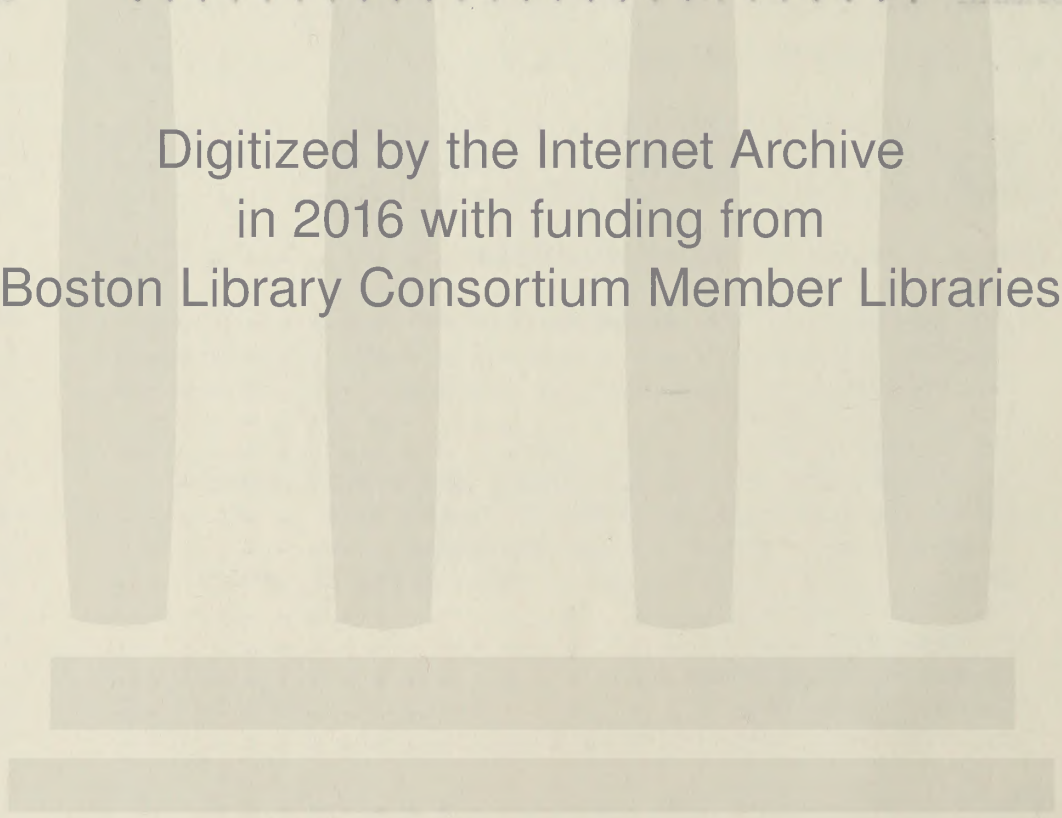

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CHAPTER I

INTRODUCTION

For many years society has been boldly confronted with, and cautiously dealt with what has so often been called "the alcohol problem", "inebriety", "alcoholism", or any one of a number of other names denoting the peculiar habits of unfortunate individuals who can no longer control their drinking of alcoholic beverages, until this drinking becomes a pathological affliction. Numerous explanations have been proposed to try to answer this problem of why people indulge in excessive drinking, some of which will be discussed at further length in Chapter III. It is sufficient to note here that alcoholism, when a problem alone and set apart from other illnesses, can be an extremely difficult problem with which to cope. When, however, it also occurs in conjunction with, preceding, or following a psychosis, it is made a doubly difficult battle to handle; not only for the patient, but for the psychiatrist, social worker, and community as well.

Alcoholism is frequently believed to have its roots in one of several deep-seated personality problems and unsolved conflicts, and is often used as a means of escape from difficult, traumatic, or unpleasant situations, by individuals with certain weaknesses in their personality structure. Accordingly, one may question what effects the traumatic situations of war may have on the incidence of alcoholism in our armed forces, and how, if there is any marked increase in their drinking habits, these increases affect the veteran whose personality characteristics, family back-

ground, and environment predispose him to a mental illness. Since the Veterans Administration Hospital, where this study was made, is a neuro-psychiatric hospital which is set up for the treatment of psychotic veterans, no measure can be made here of how the stimuli of war affected the drinking habits of the neurotic veteran, or the so-called "normal" one. Instead, the question of the incidence of alcoholism among veterans, and its subsequent effects on their adjustment to the community will, of necessity, be limited to psychotic patients, or patients admitted for observation, but discharged as being "without psychosis".

One may wonder whether these alcoholic patients, or patients who exhibit a presence or history of excessive drinking, began their heavy drinking before their induction into service, or if their drinking was subsequent to their military service. Major Merrill Moore finds that in spite of routine psychiatric examinations, a number of alcoholics do enter the Armed Forces, with a variety of results and reactions on their part, ranging from a severe increase in their drinking habits, coupled with a poor or minimal adjustment to service, to a few who actually seem to benefit from the discipline of the Service, and do drink less.[1]

It is the former who is the one likely to eventually drink to such an extent as to cause his admission into a Veterans Administration Neuro-psychiatric Hospital, either as a result of an acute alcoholic episode, which may clear comparatively quickly, or with a more malignant mental

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1 Major Merrill Moore, "The Alcohol Problem in Military Service", Quarterly Journal of Studies in Alcohol, Vol. III, No. 2, September, 1942. Reprint, p. 2-5.

disease, of which perhaps his excessive drinking had been a symptom. It is the former patient too who was frequently a problem to his family and community before service, who was a constant troublemaker in service, and who, once a veteran, becomes eligible for care and treatment by the Veterans Administration if he becomes ill.

The problem of how to handle these patients, and best treat them, now frequently passes from the community or family agency, or hospital, to the local Veterans Administration hospital or clinic. This paper will endeavor to study the problem as it has occurred and has been met in one Veterans Administration Neuro-psychiatric Hospital, and especially how the Social Service Department did, or did not help the patient, to prepare him for his return to the community.

Purpose

The purpose of this thesis is to study the incidence of alcoholism among the veterans of World War II who were admitted to the Veterans' Hospital, Bedford, Massachusetts, (a neuro-psychiatric hospital) over a six month period. It is intended to examine significant points in the patient's pre-war developmental history which may have had bearing on their breaking down into an alcoholic, or other psychosis, as well as to study the role that their military service may have played in their illnesses. In addition, it is planned to investigate the hospital adjustment of these patients, as well as the adjustment they made after having left the hospital. The work done by the Social Service Department will be studied, and the benefits or effects their work had on the patients will also be evaluated. The writer further hopes to discover what additional help

could have been given to these patients or their families by Social Service, either during the patients' hospitalization, or while they were on trial visit status, and were receiving Social Service follow-up supervision, to have helped these patients make a better, more stable community adjustment.

Source of Data

The main sources of data are the case records of forty-four patients admitted to the Veterans Hospital over a six month period, January 1, 1945, through June 30, 1945. It will cover only veterans of World War II. The cases studied were selected from among the 416 patients admitted to the hospital during the above period, and were chosen because their diagnosis was one of a variety of forms of "alcoholism" given by the Medical Staff at the hospital, or because their history indicated their drinking habits to be so excessive as to be symptomatic of, or contributory to their psychosis. With the exception of two patients diagnosed "Psychoneurosis", and six diagnosed as "without psychosis", all patients studied were considered as being psychotic. This sample was chosen to include not only "pure" alcoholics, but psychotics with a history of heavy drinking as well, in order that a more accurate measure could be made of the actual incidence of heavy drinking, or alcoholism, among veterans of the war, as well as among the patients at the hospital.

The period selected for study, the first six months of 1945, seems to be a normal period, and appears to give a representative sample of the type of cases entering a Veterans Hospital, there being nothing about the

period selected which would make the sample biased in any one direction. The time selected covers winter, spring, and early summer, thereby eliminating any seasonal factors which might have entered into making the sample un-representative. In addition, at the time that these patients were admitted, this country had been at war for over three years, and there was still a considerable period before the war terminated; which would have made an appreciable number of veterans eligible for admittance to the Veterans Hospital, due to the speed-up in demobilization.

The number of cases studied, forty-four, seems to be a large enough sample upon which to draw conclusions, and, as was mentioned, represents all patients admitted with a diagnosis of "alcoholism", or one of its derivitive diagnoses, or who have had a history of severe and excessive drinking.

CHAPTER II

THE VETERANS ADMINISTRATION HOSPITAL

A Description of Hospital Policies

The Veterans Administration Hospital in Bedford is rather typical of many such neuro-psychiatric hospitals scattered throughout the country. This hospital serves the New England area largely, the greater majority of the patients served being from that section. It does have patients from other sections of the country, however, on occasion. All of the patients in this study were from Massachusetts, or its neighboring states. The hospital has a capacity of over 1700 beds, and was created by the Federal Government to care for, treat, or observe, qualified male veterans of the Armed Forces, who served in either peace or war time, and who are suffering from a neuro-psychiatric disability. To qualify for a bed, the veteran must have been discharged from service under conditions other than dishonorable, and must not have been discharged from this, or another Veterans Hospital against medical advice within ninety days of his admission.

Patients are admitted directly from a neuro-psychiatric hospital of the branch of service in which the patient was serving, in which case, he is discharged from the service at this hospital, and into the custody of the Veterans Administration. In this study there were seventeen patients admitted directly from the services, or 38.6 per cent of the total. Patients are also admitted on transfer from State Hospitals, when they qualify for admission to this hospital. Four patients, or 9.1 per cent were admitted in this manner. Patients are also admitted directly from

their homes, either on the referral of the family itself, a local physician, or through the advice of an out-patient department of a Veterans Administration, or other hospital clinic. Twenty-three patients, or 52.3 per cent of these patients, were admitted to the hospital in this manner.

TABLE I

POINT FROM WHICH PATIENTS WERE ADMITTED

Place	Number	Per Cent
Home	23	52.3
Service	17	38.6
State Hospitals	4	9.1
Total	44	100.0

The hospital follows the rules set down by the Massachusetts Division of Mental Hygiene for the care and commitment of mentally ill patients. Patients reside on open or closed wards, depending on their condition, the wards being divided among four so-called Services.

1. Admission Service: accepts and disposes of all newly admitted patients. New patients frequently reside on this ward, unless their condition is suicidal, homocidal, or highly disturbed.

2. Acute Service: includes the disturbed, over-active or agitated patients, as well as those being observed for suicidal tendencies.

3. Semi-Acute Service: includes those patients emerging from their psychosis, but still needing somewhat close supervision.

4. Continued Treatment Service: includes those patients who are preparing to leave the hospital, or who do not require close supervision.

Patients who are regularly committed can leave the hospital for extended periods, with the permission of the medical staff, in one of two ways; trial visit or discharge. In the former instance, trial visit is granted either on the initiative of the ward physician, or on request by the patient's family, after the patient's case has been reviewed and the patient interviewed before the medical staff. With their consent, he may then be granted a visit home for a period of ninety days. This may be extended up to one year, provided the patient adjusts satisfactorily at home, and at the end of the latter period, the patient may be discharged completely from the hospital jurisdiction. In this study, nine patients, or 20.5 per cent of the total studied, left the hospital on trial visit status.

Patients appearing in remission of symptoms, or who appear to have made a good social recovery, may be granted an outright discharge from the hospital, rather than a trial visit. As in the trial visit, the patient's case must be reviewed before the staff, and their consent for discharge granted. Of the cases studied, twenty-five, or 56.8 per cent, received complete discharges.

When a competent patient insists on discharge before his examination or observation period is completed, or if he refuses to cooperate in such examinations; or when a patient's guardian or family insists upon the release of an incompetent and psychotic patient, which the staff feels is

in need of further hospitalization, the patient may be discharged against medical advice, in which case he may not return for treatment at a Veterans Administration hospital for ninety days.[1] There were no cases in this study with such a discharge. Ten patients (22.7 per cent) are still hospitalized.

TABLE II

HOSPITAL POPULATION STATISTICS

Disposition	Number	Per Cent
Trial Visit	9	20.5
Discharge	25	56.8
Still Hospitalized	10	22.7
Total	44	100.0

In addition to the regular commitment procedures, patients may come into the hospital voluntarily, to remain for diagnosis and study. They may leave upon giving a three day notice of intent to leave. Intoxicated patients may enter on a voluntary inebriate commitment, which is similar to a voluntary commitment. Other patients admitted as observation patients remain on such status for a period not to exceed forty days, or until they are regularly committed or discharged. The remainder of patients can enter the hospital under a temporary care arrangement, in which case they remain here for ten days, unless regularly committed or dis-

1 Regulations and Procedures, Veterans Administration, Washington, D.C., p. 213-4R.

charged.

The Functions of the Social Work Unit

In a neuro-psychiatric hospital, such as the one in which this study was made, it is the function and duty of the social work unit to collaborate with the medical staff in obtaining social history material, and to treat the personal circumstances related to the veteran's health, recovery, and community adjustment, to reduce his period of disablement as efficiently as possible.[2]

In the ideal case, it is hoped that the social worker will obtain a complete social history on every patient admitted to the hospital, and particularly in cases of patients admitted from their homes. The worker would then be in a position to follow through with the family, offering any assistance and advice as necessary. In the ideal case, her next step might be in making a home visit (called pre-parole) just prior to the time the patient is eligible to return home, to determine the family situation to which the patient would return, to assist the physicians in their disposition of the patient. Her next step would be to interview the patient before he left the hospital on either trial visit or discharge, to offer him whatever advice and counsel she can, to help him in adjusting to the community again. Again, in the ideal case, the next step would be for the worker to make periodic home visits to see the patient, as necessary, to give him the assistance he might need. This social service follow-up is given only to patients who are on trial visit status, as the hospital's

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2 Ibid., p. 191-194.

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2 Ibid., p. 191-194.

jurisdiction ceases when a patient is discharged. In cases where the patient's home is not within a reasonable distance of the hospital, other agencies cooperate to render social service contacts on request, i.e., the Red Cross, Family Agencies, or other Veterans Administration hospitals or offices.

Unfortunately, during the time covered by this study, the Social Service unit was severely handicapped in its work by being understaffed, there were only one chief social worker, one regular worker, and two full-time students in the department. A third student arrived at the hospital late in May for a full-time block placement, but she did not assume responsibility for a full case load until mid-June. Unfortunately therefore, the social service investigations and follow-up supervision in all cases were not as widespread as the needs called for.

Of the patients studied, no patient received full social service care. That is, in no case did the social worker take a social history on the case, followed by a pre-parole visit to the home before the patient left the hospital, followed by supervision care of the patient while he was on trial visit status. Eight patients' families had just one contact with a social worker, by giving a social history, either to a worker at this hospital, or to a worker at the hospital from which the patient was transferred. One patient, in addition to these eight, received follow-up care, after he left on trial visit, in addition to having a social history given. Another patient whose family gave a social history had another contact with social service through a pre-parole visit. Two patients received only trial visit supervision; three patients received only pre-

parole investigations. Only one patient was given supervision care, in addition to having a pre-parole contact made. Twenty-eight patients did not have a social history, pre-parole contact or supervision care.

TABLE III

SOCIAL SERVICE GIVEN TO PATIENTS STUDIED

Service	Trial Visit	Discharge	Still Hospitalized	Total	Per Cent
Social History	1	4	3	8	18.2
With Pre-parole	1	0	0	1	2.3
With Supervision	1	0	0	1	2.3
Pre-parole	1	0	2	3	6.8
With Supervision	1	0	0	1	2.3
Supervision	2	0	0	2	4.5
All Three	0	0	0	0	0.0
None	2	21	5	28	63.6
Total	9	25	10	44	100.0

The reader should bear in mind, however, that of these twenty-eight patients who had no recorded contact with Social Service, twenty-one were given complete discharges from the hospital, and were thereby ineligible to receive follow-up care from the hospital worker. Five patients were still hospitalized, and would therefore not be getting follow-up supervision. Only two patients out on trial visit status had had no follow-up supervision at all from social service. Both of these patients lived out of the state, however, and would not come under the jurisdiction of a hospital social worker, but rather of a worker attached to the nearest Red

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SOCIAL SERVICE GIVEN TO PATIENTS STUDIED

Service	Trial Visit	Discharge	Still Hospitalized	Total	Per Cent
Social History	1	4	3	8	12.5
With Pre-parole	1	0	0	1	1.5
With Supervision	1	0	0	1	1.5
Pre-parole	1	0	2	3	4.5
With Supervision	1	0	0	1	1.5
Supervision	2	0	0	2	3.0
All Three	0	0	0	0	0.0
None	2	21	3	26	40.5
Total	5	25	10	64	100.0

Cross chapter, or Veterans Administration office, who would then be responsible for forwarding periodic reports on the patient's progress to this hospital.

The writer would also like to point out again that each patient is seen by a social worker before he leaves the hospital on trial visit, or is discharged. Inasmuch as no records of these contacts are kept, however, no analysis of these interviews can be made. Neither are records kept of any interviews with patients while they are hospitalized, if any such contacts are made; therefore, this service could not be evaluated either.

It is hoped that before too long, a time will come when each patient committed to this hospital, as well as his family, when necessary, will be able to receive maximum benefit of hospitalization, through the guidance and help of the Social Service unit, working hand in hand with the Medical Staff. This can be achieved by an increased recognition of the work which the social worker can do in helping the family understand both the patient and his illness, as well as an increase in the number of trained psychiatric social workers.

CHAPTER III

ALCOHOLISM AND THE PSYCHOSES

Definition of an Alcoholic

Before entering into an analysis of the illnesses of the patients studied, it would be wise to determine just what is meant by the term an "alcoholic". This is a term used to describe a person who drinks excessively, and may or may not be associated with a mental disorder. Cleckly[1] believes that anyone who is an abnormally heavy drinker is also invariably bound to be suffering from some other personality disorder or defect. He found that every abnormal drinker he observed showed clear evidence of either psychopathic personality, some psychosis, or, in varying degrees, demonstrated some neurotic maladjustment. The cases studied in this paper, while falling among the classes of psychoses, for the most part, also include a number of patients who, though not psychotic, do demonstrate some degree of abnormal personality traits.

There have been innumerable definitions of an alcoholic set down by writers, three of which will be mentioned here, to present some idea of the variety of thinking prevalent in this area.

Haggard and Jellinek feel that a chronic alcoholic is one "who from prolonged excessive use of alcoholic beverages, usually over many years, finally develops definite physical or psychological changes."[2]

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1 Hervey Cleckly, The Mask of Sanity, p. 250-251.

2 Howard W. Haggard and E. M. Jellinek, Alcohol Explored, p. 15.

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1 Harvey Cleckly, The Mask of Sanity, p. 380-381.

2 Howard W. Haggard and E. M. Jellinek, Alcohol Explored, p. 15.

Seliger,[3] on the other hand, believes that an alcoholic is one who uses a narcotic, alcohol, to such an extent that drinking interferes with one or more of his life's activities. While Tiebout[4] feels that alcohol addiction is characterized by two chief elements, the first of which is a state of extreme tension, which eventually emerges into patterns of intermittence. The second stage, he feels, is one of progressive deterioration with ultimate somatic involvement.

While this study is primarily concerned with alcohol addicts, per se, it is also interested in studying the so-called "abnormal" drinkers, in order to get a more complete picture of the actual incidence of alcoholism among these patients. These "abnormal" drinkers, we feel, are those who, because of their excessively heavy drinking habits, are exposed to the gross effects of alcohol, including frequent and disabling periods of intoxication. In this, as perhaps in other studies of alcoholism and its relation to mental illness, it has often been difficult to distinguish between an "abnormal" or "gross" drinker, and a "symptomatic" drinker, that is, one who uses alcohol as a result of his disturbed mental state, and whose drinking is a symptom of his psychosis.[5]

Definition of a Psychosis

What then is a psychosis? Grinker and Spiegel[6] define it as:

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3 Robert V. Seliger, A Guide on Alcoholism for Social Workers, p. 11

4 Harry M. Tiebout, "The Syndrome of Alcohol Addiction", Quarterly Journal of Studies in Alcohol, Vol. 5, March, 1945, p. 11.

5 Haggard and Jellinek, op. cit., p. 14.

6 Roy R. Grinker and John P. Spiegel, Men Under Stress, pp. 237;342.

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5 Maggard and Jellinek, op. cit., p. 15.

6 Roy R. Grinker and John P. Spiegel, Men Under Stress, pp. 287;362.

> A profoundly regressive reaction in which there is considerable break with reality. The reality testing functions of the ego are lost or diminished, so that the unconscious drives or forces are more or less openly expressed. . . Psychoses . . . are regressive in that old infantile modes of thinking and behavior are reestablished.

How then can we differentiate a psychosis as being purely "alcoholic", as distinguished from an ordinary psychosis? Haggard and Jellinek[7] feel that a psychosis is truly "alcoholic" if it probably would have been avoided, but for the patient's excessive drinking. Symptomatic drinking, therefore, would not satisfy this criterion, and would be properly labeled among the true psychoses.

We see then that alcohol may enter as an etiological factor in the production of symptoms, usually considered to be distinct from the so-called alcoholic psychoses, and it may also be associated with actual psychoses, i.e, the manic-depressive syndrome, dementia praecox, etc. However, when attacks of these latter psychoses are brought on by alcoholic indulgence, probably the psychoses are considerably modified as a result of the drinking patterns, and may present a somewhat atypical picture.[8]

For many years people who suffered from mental illnesses, and who were also heavy drinkers, puzzled their families, as well as some medical authorities, who wondered whether the mental illness was caused by the heavy drinking, or vice versa. In addition, there has existed much confusion between diagnosing a true psychosis, as differentiated from an alcoholic psychosis. Thus, there have been found several cases who might be

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7 Haggard and Jellinek, op. cit., p. 221.

8 William A. White, Outlines of Psychiatry, p. 274.

diagnosed as "alcoholic psychoses", but who were actually suffering from a mental illness. In these cases, their delusions and hallucinations were resultant not from the drinking, but from their psychoses, of which the drinking was merely symptomatic. Quite often, at the beginning of dementia praecox, the sufferer may attempt to escape from the bewildering sensations which plague him by drinking excessively.[9] Bleuler, however, was the first to call attention to the fact that most of the cases which he classified as "acute alcoholic hallucinosis" really belonged in the dementia praecox group, and he stressed the difficulty in differentiating the cases in which the excessive drinking was merely superimposed on an underlying schizophrenic process.[10]

C. S. Read, as quoted by White,[11] sums up the psychology of alcoholism so far as it relates to the psychoses as follows:

> Alcohol is taken to promote the social instincts, to alleviate and narcotize the many mental conflicts to which we must all to some extent be victims . . . In excess it tends to destroy sublimation and aid regression, and in this way may precipitate a psychosis. The regression may be of varying degrees and may bring into conflict with the personality different impulses and desires previously more or less successfully expressed. Of these, the homosexual impulse is found on analysis to be the most frequent, the resulting conflict being very liable to result in paranoid states . . . It must be noted too, that with the aid of alcohol the psyche defends itself against mental pain, pleasure is gained by the freedom from inhibitions, and compensations occur, though often at the expense of sanity.

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9 Haggard and Jellinek, op. cit., p. 218.

10 Jacob P. Norman, "Alcoholic Hallucinatory States", Quarterly Journal of Studies in Alcoholism, Vol. 5, March, 1945, #4, p. 563.

11 William A. White, op. cit., p. 290.

Personality Traits of Alcoholics

How can we then classify the alcoholic to distinguish him from others? And how can we anticipate, from his personality structure and behavior, just who will or will not be able to control his drinking habits so that eventually he might become sufficiently alcoholic to need psychiatric, and perhaps medical, treatment? In answering these questions, we must always remember that the alcoholic, like any other patient, is first an individual. Haggard and Jellinek,[13] and Tiebout[14] all feel that there is no uniform personality trait characterizing alcoholics. Each, however, did find certain traits or habits which were more or less common among the cases they studied.

The former found alcoholics to be "of weak restraint, mental poise and stability, having difficulty in controlling moods and desires, more selfish, conceited, and anti-social than "normal" people. They also felt that these people had greater mood changes, strong suspicious nature, were somewhat conceited, stubborn, and inclined to be scornful.[15] Tiebout found them to have a need to dominate, a prevailing negative hostile feeling tone, to have a great deal of resentment, defiance, hostility, and hidden underneath the surface, he believed they have a sour, cynical reaction about life. They are also described as having a great capacity for reaching ecstatic peaks, yet simultaneously of having a sense of loneli-

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13 Haggard and Jellinek, op. cit., p. 152.

14 Harry M. Tiebout, op. cit., p. 540.

15 Haggard and Jellinek, op. cit., pp. 541-542.

ness and isolation, or feelings of inferiority and superiority.[16]

Tiebout does feel, however, that regardless of the original type of personality, as the illness progresses each patient seems to begin to react in essentially similar ways. He groups this similarity in behavior under the heading of "egocentricity".[17] Unfortunately, due to the nature of the record kept in the hospital where this study was made, there was no way of correlating the above characteristics as given by Haggard, Jellinek and Tiebout with those of the patients studied.

From hospital records, however, it is felt that invariably, the patients studied all seemed to suffering from a fundamentally weak ego. It appears that these patients were unable to develop that part of the personality structure which would help them to meet everyday problems and situations in a normal, healthy manner. Lacking this inner security, they therefore, seemingly had to resort to alcohol as a means of temporary escape from the threats of reality. In some cases, they eventually went one step further, and retreated from reality altogether, through their psychoses. We cannot determine, from the records, whether this inability to face reality came as a result of early deprivations, frustrations, traumatic situations, or other causes. We can only observe that all of the patients studied seemingly could not face reality, in varying degrees, and all had a common denominator, alcohol, as a means of escape.

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16 Harry M. Tiebout, op. cit., pp. 541-542.

17 Harry M. Tiebout, op. cit., p. 540.

CHAPTER IV

MENTAL DISEASES OF THE GROUP STUDIED

In this chapter, it is intended to study the diseases of the block of cases studied, to try to determine the types of mental diseases, alcoholic psychoses, or both, that these veterans developed, in order to get some picture of the prevalence of both mental disease among these men who drink so heavily, as well as the incidence of alcoholic psychoses present.

The writer would like to present first a brief discussion of the types of mental illnesses found in this study. At this hospital, it is possible for a patient to carry more than one diagnosis. Some carry two, or as many as three diagnoses; that is, a patient may have two diagnoses as secondary to his main diagnosis. Thus, a patient who is believed to be suffering from a manic-depressive psychosis, but who has an underlying history of chronic alcoholism, would carry both diagnoses, and would then be rated for these disabling conditions accordingly, by the Veterans Administration rating board. While it is not too common for patients to carry more than one diagnosis, it is a policy which is used where necessary.

In this study there were seventeen patients, or 38.6 per cent of the cases studied, who carried more than one diagnosis. Of this number, two carried three diagnoses. The patients who carried a primary diagnosis of manic-depressive psychosis, or of dementia praecox, constitute a total of 38.7 per cent of the group. The alcoholic psychoses (alcoholism acute, alcoholism chronic; psychosis with alcoholic deterioration; psychosis,

intoxication alcoholic acute, paranoid type) constitute 38.6 per cent of the group. A total of eight, or 18.2 per cent were diagnosed as being "without psychosis", which includes such diagnoses as psychopathic personality, psychoneurosis, mental deficiency, and constitutional psychopathic state, and occasionally, "alcoholism acute". The remainder of the group includes such diagnoses as psychosis, post-traumatic personality disorders. (See Table IV)

It is interesting to note that a total of fourteen patients were diagnosed as "alcoholism chronic" in conjunction with their primary diagnosis, but this was as a secondary diagnosis. This is in contrast to only one patient who carried the diagnosis of alcoholism chronic alone. We may observe from this that 31.8 per cent of the patients who carry a diagnosis of chronic alcoholism also have some other mental or personality disturbance or disorder in conjunction with it. That is, their chronic alcoholism does not appear as an entity in itself, but rather accompanies other disorders. One patient even combined the chronic alcoholism along with two other diagnoses (psychopathic personality, and mental deficiency).

The two other diagnoses which were carried as secondary, were psychoneurosis, which one patient carried in addition to psychosis intoxication, acute paranoid type, and which one patient combined with alcoholism acute. Psychopathic personality was also given as a secondary diagnosis to one patient, who carried it in conjunction with a primary diagnosis of dementia praecox. (See Table V)

TABLE IV

PRIMARY DIAGNOSES OF PATIENTS STUDIED

Diagnosis	Number	Per Cent
Manic-Depressive		
Manic type	1	2.3
Depressed "	1	2.3
Dementia Praecox		
Catatonic type	7	15.9
Hebephrenic "	2	4.5
Paranoid "	5	11.4
Mixed "	1	2.3
Alcoholism Chronic	1	2.3
Alcoholism Acute	6	13.6
Psychosis with alcoholic deterioration	1	2.3
Psychosis Intoxication Alcoholic		
Acute hallucinosis	9	20.4
Acute paranoid type	1	2.3
Psychosis, Post-Traumatic		
Personality Disorders	2	4.5
Psychoneurosis	2	4.5
Psychopathic Personality		
With psychosis	2	4.5
Without "	1	2.3
Constitutional Psychopathic State	1	2.3
Mental Deficiency	1	2.3
Total	44	100.0

TABLE V

SECONDARY DIAGNOSES OF PATIENTS STUDIED

Diagnosis	Number
Alcoholism chronic (combined with)	
Alcoholism acute	2
Manic depressed, manic	1
Dementia praecox	1
Constitutional psychopathic state	1
- psychosis, post traumatic personality disorders	2
Psychosis, intoxication alcoholic	3
Alcoholism chronic (combined with both) Psychosis intoxication alcoholic Mental deficiency	2
Alcoholism chronic (combined with both) Psychosis intoxication alcoholic Psychopathic personality	2
Total	14
Psychoneurosis (combined with)	
Psychosis intoxication acute, paranoid type	1
Alcoholism acute	1
Total	2
Psychopathic personality (combined with)	
Dementia praecox	1
Total	17

TABLE V

SECONDARY DIAGNOSIS OF PATIENTS STUDIED

Diagnosis	Number
Alcoholism chronic (combined with)	
Alcoholism acute	2
Manic depressed, manic	1
Dementia praecox	1
Constitutional psychopathic state	1
- psychosis, post traumatic personality disorders	2
Psychosis, intoxication alcoholic	3
Alcoholism chronic (combined with both)	
Psychosis intoxication alcoholic	
Mental deficiency	2
Alcoholism chronic (combined with both)	
Psychosis intoxication alcoholic	
Psychopathic personality	2
Total	14
Psychoneurosis (combined with)	
Psychosis intoxication acute,	
paranoid type	1
Alcoholism acute	1
Total	2
Psychopathic personality (combined with)	
Dementia praecox	1
Total	17

The Psychoses of the Patients Studied

Dementia Praecox

Since 34.1 per cent of the group studied carry this diagnosis, it seems only fitting to discuss it briefly at this point. This illness, sometimes referred to as "schizophrenia" involves the effective life of the individual and expresses itself in disorders of feeling, of conduct, and of thought, coupled with an increasing withdrawal of interest from the reality world. The symptoms vary, but most common is a failure to display proper emotion, apathy, and indifference. There is a lack of contact with reality, and there may also be bizarre delusions, hallucinations, or ideas of reference.[1]

In this connection, the writer would like to stress again that it is often believed that cases involving alcoholics who are suffering from acute hallucinations or delusions may frequently merely be manifesting symptoms of their underlying schizophrenic process, rather than an actual acute alcoholic hallucination.

There are four main forms of dementia praecox; which are found among the cases studied. They are:

1. Catatonic
2. Hebephrenic
3. Paranoid
4. Mixed

In the catatonic type, the patient may display alternating states of depression, excitement, and/or stupor, coupled with hallucinations and delusions. Seven of the patients studied were "catatonics".

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1 D. D. Henderson and R. D. Gillespie, A Textbook on Psychiatry, p. 183.

The Psychoses of the Patients Studied

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The hebephrenic is characterized by a silliness, shallowness of affect, and gradual intellectual deterioration. Two patients were thus diagnosed.

The paranoid is characterized by ideas of reference, delusions of persecution or grandeur. Their delusions are changeable, usually unsystematized, and accompanied by hallucinations. Five of these patients were diagnosed as "paranoids".

The mixed type of dementia praecox is the patient whose symptoms combine any one of the other types, with no clear cut type predominating. One patient manifested this type of illness.

Manic Depressive Psychosis

Only two of these patients were diagnosed as having a manic depressive psychosis, one of which was felt to have the depressed phase, and one the manic phase. This disease is not as prevalent as dementia praecox. In this disease, the characteristics are periods of elation, depression, or both. The manic reaction is characterized by three primary symptoms, elation, flight of ideas, and extreme psychomotor activity. There may also be hallucinations and delusions present.[2] The one patient who carried this diagnosis, also carried the secondary diagnosis of alcoholism chronic.

The general reactions to a depressive phase are extreme depression, psychomotor retardation, difficulty in thinking. There may also be delusions and hallucinations present.

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2 A. H. Maslow and Bela Mittleman, Principles of Abnormal Psychology, p. 458.

THE ALCOHOLIC PSYCHOSES

Chronic Alcoholism

A person suffering from chronic alcoholism is an habitual drinker who frequently has to resort to alcohol to escape from reality or difficulties. Only one patient carried this diagnosis alone, but, as has been pointed out, (p. 21) fourteen carried this diagnosis in conjunction with another, or primary diagnosis.

Alcoholism Acute

This is a term used to describe those patients suffering from the gross and acute effects of an alcoholic debauch, where these effects are severe enough to require hospitalization. Frequently, these patients may be bordering on an attack of delirium tremens. They may be suffering from hallucinations. Six patients were brought to the hospital suffering with this stage of alcoholism. These patients may, or may not, be psychotic.

Psychosis Intoxication Alcoholic, Acute Hallucinosis

This phenomena is characterized by a sudden onset of symptoms, such as extreme fear, anxiety, delusions of a persecutory nature, with the sexual element predominating. Auditory hallucinations predominate over the visual.[3] The patient is usually fairly well oriented. He may present a difficult diagnostic problem, as sometimes it appears to be a psychosis resulting from alcoholism, which differs from dementia praecox by only fine

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3 Jacob P, Norman, op. cit., p. 571.

shadings.[4] This was the most common disorder of the alcoholic psychoses present in this group, with 9 patients, or 20.4 per cent diagnosed as such.

Psychosis Intoxication Acute, Paranoid Type

This is similar to the paranoid types found in dementia praecox. It is characterized by delusions of marital infidelity, and may follow an attack of the delirium tremens. This illness may have a long course, and may carry a poor prognosis, and may terminate in severe deterioration.[5] Only one patient carried this diagnosis.

Psychosis with Alcoholic Deterioration

One patient carried this diagnosis. This ailment is characterized by psychotic symptoms, coupled with marked intellectual deterioration.

Psychosis with Post-Traumatic Personality Disorders

This disorder follows a severe traumatic injury, usually to the brain, and results in marked personality changes, coupled with psychotic symptoms, as a result of the injury. Two patients were thus diagnosed.

Delirium Tremens

In addition to their illness, many patients were brought in with acute or subsiding stages of delirium tremens (the "d.t's"). This is a mental disorder of brief duration, and comes on only after many years of drinking, and is usually preceded by a severe alcoholic debauch. It appears rather suddenly, and is characterized by coarse tremors of the hands

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4 Haggard and Jellinek, op. cit., p. 240.

5 William A. White, op. cit., p. 284.

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4 Haggard and Jellinek, op. cit., p. 345.

5 William A. White, op. cit., p. 258.

and tongue, and vivid hallucinations, mainly visual, though they may also be auditory, or both. These visions and voices are often of a threatening nature, and may be an expression of the patient's fears.[6]

NON-PSYCHOTIC DIAGNOSES

Psychoneurosis

This is a condition involving a disturbance of psychological or physiological functions, or both, arising as a reaction to stress, with no serious impairment of the sensory or social reality functions.[7] Two patients were diagnosed thus.

Psychopathic Personality

These patients, of which four in this study were diagnosed, three as with psychosis, and one as without psychosis, are curious enigmas of psychiatry. These are patients who have no disturbance of the reasoning process, but conduct themselves in a bizarre, absurd manner, with no restraints, inhibitions, or ability to learn from experience. They cannot relate to a true love object.[8]

Mental Deficiency

This is, of course, characterized by a defective intellectual capacity. Two patients carried this diagnosis as secondary to their alcoholic psychosis.

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6 Haggard and Jellinek, op. cit., pp. 232-233.

7 Maslow and Mittleman, op. cit., p. 607.

8 Cleckly, op. cit., p. 251.

Constitutional Psychopathic State

One patient was diagnosed thus. This disorder resembles the psychopathic personality in that these people behave in odd, bizarre manners, but it is regarded as more of a constitutional defect present in the personality than one observes in the ordinary psychopath. It may accompany an emotionally unstable behavior.

The above information is presented as background material for the reader's understanding of the illnesses of the patients in the group studied.

CHAPTER V

ANALYSIS OF CASE MATERIAL

As has already been mentioned on page 18, there is no agreement among authorities regarding the common personality trends predisposing a person to alcoholism; although we can say that authorities agree that there are no such common trends of the personality. But what about the early childhood, developmental period, general patterns of adjustment, environment? What common factors, if any, can be found in a block of cases such as these now being studied, which might indicate how these patients developed into their maladjusted patterns, and how they managed to adjust to their life's situations?

In this chapter it is planned to examine the patient's history, with an intention of noting any common factors present in the lives of these men. Their military adjustment will also be viewed, to try to ascertain how these men managed to adjust under the rigors of the armed forces, and combat. The question of their adjustment to hospitalization and, subsequently, their re-adjustment to the community after leaving the hospital will be considered. The role of Social Service in this connection will also be evaluated.

Background of the Patients Studied

Here the writer would like to study the types of patients being examined to see what elements, if any, were present in their childhood which might give a clue as to the reasons behind their maladjustment.

Major Merrill Moore[1] feels that the roots of alcoholism are laid in childhood or adolescence, and may result from the patient having an overly dominant father, though it may be either parent who is dominant, or else, over-dominance by one parent coupled with over-indulgence of the other. Unfortunately, information about the families of these patients is meager and does not include sufficient data regarding this point to be statistically valid.

The records do, however, indicate, in most instances, when mental illness, or alcoholism, or both, is present in the family, and the question might logically arise then as to the presence of these factors in the background of these patients. It is felt impossible to evaluate the precise role that heredity or environment could have played in the development of these sick patients, nor is that the purpose of this paper. However, the writer does feel that it is important to bear in mind that alcoholic or mentally unstable parents, being maladjusted, will have some difficulty in raising their children to be normal, and to have healthy personalities. In addition, there is also the possibility that early identification of the child with the alcoholic parent may play some part in the etiology of the child's illness. Haggard and Jellinek[2] feel that an individual with an heredity of alcoholism will have a greater chance to succumb to alcohol than others, but that actual heredity, per se, is negative.

What then is the incidence of alcoholism and/or mental disease

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1 Major Merrill Moore, "Toward a Better Understanding of Alcoholism", Alcohol Hygiene, Vol. II, No. 1, January-February, 1946, p. 6.

2 Haggard and Jellinek, op. cit., p. 146.

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1 Major Merrill Moore, "Toward a Better Understanding of Alcoholism", Alcohol Digest, Vol. II, No. 1, January-February, 1950, p. 5.

2 Haggard and Jellinek, op. cit., p. 146.

among the parents of these patients? Upon examination, it was found that in 27.3 per cent of the cases, the father had been an alcoholic. In no cases was the mother an alcoholic, nor were any parents both alcoholic. In 72.7 per cent there was no reported alcoholism in either. In one case the father was an alcoholic and the mother mentally ill.

The fact that alcoholism seemed prevalent in the father of these men, and non-existent, as far as is known, in the mothers, led the writer to wonder if the element of father identification was strong in these cases. Other speculations can be formed, however, such as; were these patients dominated by the mother, since the father apparently was weak? Were they over-indulged by one parent, and so on. Since no data is available, however, these must remain speculations, and no conclusions can be drawn, particularly when it is considered that in 72.7 per cent of the cases there was either no history of alcoholism, or else such a history was unreported.

TABLE VI

REPORTED ALCOHOLISM IN PARENTS OF PATIENTS STUDIED

Parent	Number	Per Cent
Father	12	27.3
Mother	0	0.0
Both	0	0.0
Neither	32	72.7
Total	44	100.0

As regards mental illness in the parents of these patients, the vast majority (77.3 per cent) had either no history of mental illness in the family, or else such a history was not disclosed to the hospital. Of those who did have mentally ill parents, however, the tendency was for the mother to be ill, with seven patients, or 15.9 per cent, having had a mother who was mentally ill. Only one patient had a father who had suffered a mental disorder. No patient had both parents mentally ill. In two cases there was a history of such illness in the family, but not in the parents.

TABLE VII

MENTAL ILLNESS IN PARENTS OF PATIENTS STUDIED

Parent	Number	Per Cent
Father	1	2.3
Mother	7	15.9
Both	0	0.0
Neither	34	77.3
History in family	2	4.5
Total	44	100.0

Childhood Adjustment of Patients

The writer would like now to examine the early adjustment that these men made, in the light of Major Moore's opinion that alcoholism has its roots laid in childhood. It cannot be determined just how, or why, these seeds of maladjustment were planted, yet, by examining these cases, it may

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be possible to find out how many were making poor adjustments as early as their childhood or adolescence. Due to the nature of our records, it was decided to use the patient's adjustment to school as an indication of their general childhood adjustment. The writer realizes that this is not as accurate as if there was an actual means of measuring the individual's adjustment at home, in school, and in the community. Lacking this, however, the child's school adjustment will be used, feeling that if a child is not adjusting to school, is having difficulty there, or is manifesting behavior problems, then he is probably also having some such difficulty in the home, either in conjunction with, or because of, his failing adjustment to school. One must realize that the child who is getting along well in school, may be maladjusted at home, but it is felt that this number is negligible.

In a great many cases, the school maladjustment may be due to an inability to learn based on mental deficiency, either slight or great; in others it may be a product of the child's other more serious behavior problems. This, however, cannot be evaluated in this study, but the reader is asked to bear these points in mind.

The figures for these cases, as regards school adjustments, are given in Table VIII. In this Table a "good" adjustment is one where the patient had no reported difficulty with schooling, was never left back, did not play truant, had no known behavior problems, and in general, made a satisfactory school adjustment. A "fair" adjustment is one where the child seemed to have some difficulty in learning, or adjusting, but managed to struggle on without getting into any serious difficulty. A "poor"

adjustment is one where there was truancy, the child was left back several times, manifested serious behavior problems, and was generally a difficult problem to handle. These data indicate that eighteen patients, or 40.9 per cent of all patients, made a poor adjustment in their schooling, indicating that their inability to adjust seemed to have begun, in this large amount of cases, as early as their childhood.

TABLE VIII

SCHOOL ADJUSTMENTS OF PATIENTS STUDIED

Adjustment	Number	Per Cent
Good	8	18.2
Fair	10	22.7
Poor	18	40.9
Unknown	8	18.2
Total	44	100.0

From the above figures it may be observed that well over half of these patients (63.6 per cent) made either a poor, or only fair, adjustment in their schooling. Since alcoholism is said to be a means of escape from difficult situations, it might be revealing to examine the actual amount of schooling that these patients received to try to discover if they left school in early grades, presumably not being able to make the adjustment, or if they managed to struggle on through despite other handicaps.

The figures given below in Table IX indicate that 72.8 per cent of these men had only up to two years of high school, while almost one half

of these patients, or 47.8 per cent, finished only the eighth grade. From this one can infer that these men, not being able to adjust scholastically, left, or were expelled from school, before completing their education. On the other hand, one can also infer that instead of this being the beginning of their "escapist" attitude toward life (as demonstrated by their incomplete education), it is an indication that this type of patient is drawn from an intellectually inferior group of men. It might also mean that the group is drawn from a low economic group where the patients had to leave school at an early age to support their families. In the light of the large percentage of men who made poor school adjustments, however, we feel that this latter point is not to be stressed. However, this all is conjecture and, unfortunately, cannot be measured reliably from the data in our records.

TABLE IX

AMOUNT OF EDUCATION OF PATIENTS STUDIED

Amount of Education	Number	Per Cent
1st to 6th grade	5	11.4
7th to 8th "	16	36.4
1-2 years high school	11	25.0
3-4 " " "	3	6.8
1-2 " college	3	6.8
College graduates	2	4.5
Graduate school	2	4.5
Unknown	2	4.5
Total	44	99.9

Drinking Habits of Patients Studied

It can be observed from the above tables that the trends of instability seem to have been started in early childhood in many of the cases studied. One may wonder then how this instability affected the drinking patterns of the patient, that is, just when did he begin to drink? Did he begin to drink early in life? The following table gives some indication of these trends. Of the cases studied, almost one-half, 49.9 per cent, began to drink during the ages of fifteen to twenty-five, or relatively early in life. A total of 29.5 per cent actually began to drink during their adolescence, during the period of fifteen to eighteen. One patient began to drink heavily at twelve years of age.

TABLE X

AGES WHEN PATIENTS STUDIED BEGAN TO DRINK

Age	Number	Per Cent
Before 14	1	2.3
15-18	13	29.5
19-25	9	20.4
26-35	8	18.2
36-over	1	2.3
Unknown	12	27.3
Total	44	100.0

In the development of an alcoholic psychosis, the number of years that a patient has been drinking has a great deal of bearing upon the onset of the illness. Of these cases, 25 per cent had been drinking for from

ten to fifteen years, while only 9 per cent had been drinking for three years or less. From this, one can eliminate the possibility, in the majority of cases, of their service in the Armed Forces as being directly contributory to, and a cause of, these men turning to alcohol. It must, however, be borne in mind that these are patients suffering from, and needing treatment for, alcoholic or other psychoses, and as such, are a very special class of veterans due to the nature of their disability. Therefore, no general conclusions on the relative number of other veterans who resorted to drinking to escape from the rigors of military life and combat can be drawn from our data.

TABLE XI

NUMBER OF YEARS PATIENTS STUDIED HAVE BEEN DRINKING

Number of Years	Number of Patients	Per Cent
Less than 1	2	4.5
2-3	2	4.5
4-5	4	9.1
6-10	7	15.9
11-15	11	25.0
16-20	4	9.1
21-over	2	4.5
Unknown	12	27.3
Total	44	99.9

Sexual and Marital Adjustments of Patients Studied

Many people have felt that alcoholics are prone to be maladjusted in the sexual area, and that they are frequently homosexual, either overtly or subconsciously. It has also been said that their homosexual tendencies are due to, or linked up with, a variety of other factors in the patient's entire psycho-sexual development. Seliger[3] points out that these alcoholics often have a lack of masculine security and aggression, often have feelings of inferiority, and are especially inclined to be envious of successful males in their families.[4] It was found in these cases that only 20.5 per cent of the patients had had an active homosexual experience, while 11.3 per cent admitted homosexual desires, but had had no experiences. Of the nine patients who admitted having had homosexual experiences, only three, or one-third, preferred this to normal heterosexual experience, while six, or two-thirds, have since made heterosexual adjustments, after having one or a few scattered overt homosexual experiences. Only one patient had never had a sex experience of any kind.

On the basis of the data presented in the table below, one can conclude that fourteen patients, or 31.8 per cent, admitted homosexual tendencies, either overt or suppressed. The actual figure may, of course, be larger than that, when one considers that these tendencies were unreported in 25 per cent of the cases, as well as the fact that many of these patients, or their families, may have repressed these facts in giving history information. Unfortunately it is not possible to compare these figures

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3 Seliger, op. cit., pp. 26-27.

4 For an example of this, see Charles Jackson's novel, The Lost Week-end.

with those of homosexuality of all patients admitted to the hospital as no such data is available.

TABLE XII

INCIDENCE OF HOMOSEXUALITY IN PATIENTS STUDIED

Sex Experience	Number	Per Cent
Overt homosexual experience	9	20.4
Homosexual desires	5	11.4
Active heterosexual experience only	18	40.9
No experience	1	2.3
Unknown	11	25.0
Total	44	100.0

Almost one-third of these men have disturbed sexual adjustments. This, coupled with their excessive drinking habits, would perhaps lead one to wonder if they might not also have stormy and difficult marital life. In examining the data among these cases as regards marital adjustments, we found that 36.4 per cent of these patients were married. Of that figure, 4.5 per cent (two patients) were divorced, and the same number separated from their wives at the time of their admission to this hospital. In three of these four cases the husband's excessive drinking is said to have caused the marital rift, while in one case the rift was said to have been due to the dominating attitude of the wife and her family.

Of the remaining twelve still married, five are reportedly making good marital adjustments, while four are making failing adjustments; that is, the marriage was satisfactory until the onset of the patient's illness,

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Of the remaining twelve still married, five are reportedly making good marital adjustments, while four are making failing adjustments; that is, the marriage was satisfactory until the onset of the patient's illness,

or excessive drinking, after which the home adjustment was poor. Three patients reportedly are making unsatisfactory marital adjustments. Of these latter three, two reportedly drink heavily to escape from an aggressive, unpleasant, domineering wife. No definite reason was cited for the third patient's unsatisfactory home adjustment, other than his intolerable drinking habits.

TABLE XIII

MARITAL STATUS OF PATIENTS STUDIED

Marital Status	Number	Per Cent
Single	28	63.6
Married	12	27.3
Divorced	2	4.5
Separated	2	4.5
Total	44	99.9

In examining these cases one step further, it was discovered that one strong characteristic of these patients is their early promiscuity, and a marked trend toward marriages where the wife was from one to ten years older than the patient. This was true of six of the twelve patients who were married.

Their early promiscuity is indicated by the fact that a total of fourteen of these patients had had some sex experience between the ages of twelve and seventeen. From these data no conclusions can be drawn, however.

Economic Status of Patients Studied

To carry the investigation further as to the types of men these patients represent, their professional status, the types of work and the walks of life they represent have been studied. In Table XIV a skilled worker is one who knows a definite trade or skill, such as plumber, welder, shoemaker, carpenter. An unskilled person is one whose trade utilized no special skill, knowledge, or training, such as a mill or factory hand; it also included common laborers.

From these data, one can observe that over one-half of these patients, 56.8 per cent, come from the unskilled, or laboring class. Again the data is not such as to reveal whether this results from a cultural pattern in which laborers, unskilled workers and the like are more prone to drink excessively than others. There is also a possibility that alcoholics (or other mentally ill patients) coming from a higher income and industrial group might be more likely to seek psychiatric help from a private hospital, rather than a Veterans Administration hospital, despite the fact that they are eligible for hospitalization here.

One can notice, too, the small group of farmers, professional workers and students represented (one patient in each category) as well as only four "white collar" workers, clerks and salesmen.

TABLE XIV

JOBS AND PROFESSIONS REPRESENTED BY PATIENTS STUDIED

Job Status	Number	Per Cent
Skilled workers	12	27.3
Unskilled "	25	56.8
Clerical and Sales	4	9.1
Students	1	2.3
Professional	1	2.3
Farmers	1	2.3
Total	44	100.1

In making a study of the patient's work status in the community, the writer also endeavored to link this up with the patient's total economic, social and community adjustment, and make some evaluation of this total measure of adjustment. In doing this, the general picture of the patient was evaluated, and graded as being good, fair, or poor. A "good" adjustment is one where the patient was seemingly well-oriented and adjusted in the home and community; a "fair" adjustment being one where he was making only a marginal adjustment, and a "poor" adjustment was considered to exist where the patient's integration and adjustment in the home and community was decidedly unsatisfactory. These evaluations were made on the basis of the patient's pre-service history, which, as will be seen (p. 44) coincides, for the most part, with the period before most of these men were requiring hospitalization, although, as was pointed out, (pp.30-31) the roots of instability were present early in the lives of most of these

TABLE XIV

TYPES AND PROFESSIONS REPRESENTED BY PATIENTS STUDIED

Job Status	Number	Per Cent
Skilled workers	12	27.3
Unskilled "	25	56.8
Clerical and Sales	4	9.1
Students	1	2.3
Professional	1	2.3
Farmers	1	2.3
Total	44	100.1

men.

Their general adjustment is given in the following table.

TABLE XV

GENERAL PRE-WAR ADJUSTMENT OF PATIENTS STUDIED

Adjustment	Number	Per Cent
Good	8	18.2
Fair	20	45.4
Poor	10	22.7
Unknown	6	13.6
Total	44	99.9

Note: For a comparison of the pre-war adjustment with these patients' post-hospitalization adjustment, see p. 54.

Military Adjustment of Patients Studied

Having investigated briefly some significant trends in the early lives of these patients, as well as their general pre-war or pre-service adjustment, one can continue one step further and observe just what their reactions were in and to their period of military service, and how they adjusted to this experience. It has previously been noted (p. 7) that only seventeen patients broke down so severely in service that they had to be hospitalized here directly from a neuro-psychiatric hospital while still in service. The remainder managed to struggle along, and suffered illnesses requiring hospitalization after their discharge from service and return to the community. True, the great majority of these latter patients were separated from service with neuro-psychiatric discharges, yet their ill-

TABLE XV

GENERAL PRE-WAR ADJUSTMENT OF PATIENTS STUDIED

Adjustment	Number	Per Cent
Good	9	10.2
Fair	20	45.4
Poor	10	22.7
Unknown	5	11.3
Total	44	99.6

Note: For a comparison of the pre-war adjustment with these patients' post-hospitalization adjustment, see p. 64.

Military Adjustment of Patients Studied

nesses were not, it would seem disabling enough as to require hospitalization. It would have been interesting if their home or community situations after discharge could have been evaluated carefully to observe any significant trends which might have precipitated their breakdowns. Unfortunately, however, the records are too incomplete to undertake a study of that type which would have been at all valid. One would like to know more about what their military service meant to these men in terms of increasing (or decreasing) their drinking habits, and in precipitating their illness. Of the forty-four patients studied, six had actually been hospitalized in state hospitals or alcoholic sanitaria before their induction into service. This reveals that over 85 per cent of these men managed to keep out of hospitals, until after their induction and period of military service. Perhaps, though, one should not dwell on this figure, but rather be interested in the fact that the Army did induct six men who had previous breakdowns, and that these men have all required subsequent periods of hospitalization at the expense of the federal government. Just what their adjustment might have been had they not been inducted, cannot, of course, be estimated.

At this point one can observe the general adjustment that these patients made while in service. In the following table the amount of time spent by these patients in service before discharge has been noted. The bulk of the cases (77.2 per cent) served between six months and three years.

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At this point one can observe the general adjustment that these patients made while in service. In the following table the amount of time spent by these patients in service before discharge has been noted. The bulk of the cases (77.2 per cent) served between six months and three years.

TABLE XVI

LENGTH OF MILITARY SERVICE OF PATIENTS STUDIED

Period of Service	Number	Per Cent
Less than 3 months	4	9.1
4 to 6 months	1	2.3
7 months to 1 year	9	20.4
2 to 3 years	25	56.8
4 to 5 years	5	11.4
Total	44	100.0

In estimating the adjustment to service made by these patients, a "good" adjustment is one where the patient received no known company or other punishments, presented no disciplinary problems and, in general, made a satisfactory relationship and adjustment to life in the service. A "fair" adjustment would be made by one who had minor punishments, whose drinking or other behavior patterns made him a slight problem to his unit, who had mild punishments, but who had no disturbing difficulties in service. A "poor" adjustment would be made by the obviously rebellious soldier or sailor who was constantly in difficulty, could not obey orders or relate to his buddies, had courts martials, and whose drinking or behavior problems severely interfered with his performance of his military duties. In this group fell each of the psychopathic cases found in the study, Of these cases, only 15.9 per cent made a reportedly good adjustment to service, while 25 per cent made decidedly poor adjustments.

TABLE XVI

LENGTH OF MILITARY SERVICE OF PATIENTS STUDIED

Period of Service	Number	Per Cent
Less than 3 months	4	9.1
4 to 6 months	1	2.3
7 months to 1 year	9	20.4
2 to 3 years	25	56.8
4 to 5 years	5	11.4
Total	44	100.0

TABLE XVII

MILITARY ADJUSTMENTS OF PATIENTS STUDIED

Adjustment	Number	Per Cent
Good	7	15.9
Fair	17	38.6
Poor	11	25.0
Unknown	9	20.4
Total	44	99.9

Of these patients, fourteen served only in the United States, six were overseas, but not in combat, while twelve, or 27.3 per cent, of the group saw actual combat duty overseas. Of this latter group, four reportedly made a good adjustment in service (prior to the onset of their illness), five a fair adjustment, while three made definitely poor adjustments.

TABLE XVIII

PLACE OF MILITARY SERVICE OF PATIENTS STUDIED

Place of Service	Number	Per Cent
Never overseas	14	31.8
Overseas, not in combat	6	13.6
Overseas, in combat	12	27.3
Unknown	12	27.3
Total	44	100.0

TABLE XVII

MILITARY ADJUSTMENTS OF PATIENTS STUDIED

Adjustment	Number	Per Cent
Good	7	15.9
Fair	17	38.6
Poor	11	25.0
Unknown	9	20.4
Total	44	99.9

Of these patients, fourteen served only in the United States, six were overseas, but not in combat, while twelve, or 27.3 per cent, of the group saw actual combat duty overseas. Of this latter group, four reportedly made a good adjustment in service (prior to the onset of their illness), five a fair adjustment, while three made definitely poor adjustments.

TABLE XVIII

PLACE OF MILITARY SERVICE OF PATIENTS STUDIED

Place of Service	Number	Per Cent
Never overseas	14	31.8
Overseas, not in combat	6	13.6
Overseas, in combat	12	27.3
Unknown	12	27.3
Total	44	100.0

Grinker and Spiegel[5] point out that actual psychotic breaks are extremely rare in, or after, combat as, usually, the ordinary difficult routines of Army life have been sufficient to bring out latent psychoses in those predisposed persons long before they enter combat. They do feel, however, that some men with schizophrenic or paranoid personality structures do remain fairly stable until they go into battle, at which time they break down.

The writer found, however, that of the patients studied who saw combat duty, six broke down either during, or directly following, combat duty, but while still in service. Six others broke down after returning to civilian life with a serious illness requiring hospitalization. In both instances, five of the six patients were diagnosed here as actually psychotic, while one of the six was felt "without psychosis". In other words, only two of the twelve patients who had combat duty did not have psychotic breaks.

General Hospital Adjustment

The course of these patients up through their period of military service has been traced, and now the point has come where, since they have broken down, they are eligible for neuropsychiatric care in a Veterans Administration Hospital, and in this connection the course of their hospitalization here will be investigated.

First, however, some additional statistics regarding the type of patient studied here will be presented. It was found that his average

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5 Roy R. Grinker and John P. Spiegel, War Neuroses, p. 43-44.

age is thirty-one years, and that more than one-half of these patients (59.1 per cent) fall in the twenty-five - thirty-five year age group. These figures have been broken down to differentiate between the ages of patients still hospitalized, (the sickest patients) those out on trial visit, (the next sickest group) and those who were discharged, (those who were acutely ill) to compare the ages of these groups. Interestingly enough, it was found that the majority of the sickest patients (those still hospitalized) as well as the less severely ill patients (those discharged) fall within the twenty-five to thirty-five year group, with none of the severely ill patients being under twenty-five.

TABLE XIX

AGE ON ADMISSION OF PATIENTS STUDIED

Age	Patients on Trial Visit	Patients Discharged	Patients Still Hospitalized	Total	Per Cent
18-21	2	2	0	4	9.1
22-25	1	2	0	3	6.8
26-30	2	5	4	11	25.0
31-35	1	9	5	15	34.1
36-40	1	3	0	4	9.1
41-45	2	4	1	7	15.9
46-over	0	0	0	0	00.0
Total	9	25	10	44	100.0

In sub-dividing the group in this manner, it was found that the average age of patients still hospitalized is thirty and one-half; for those on trial visit status thirty; for those discharged thirty one and one-half, indicating that the latter group is made up of older men than the former two groups. The bulk of alcoholic psychoses, or acute cases of alcoholism, falls in this group of discharged patients, and this would follow logically since these alcoholic psychoses result only after several years of heavy drinking.

Amount of Time Hospitalized

In computing the time spent by these patients in this hospital, it was found that they spent an average of 27.5 days here before being discharged, as compared with 161.5 days, or over five months, before going out on trial visit. This can be accounted for, in that many of the patients who were discharged suffered only acute alcoholic episodes and were well enough to leave the hospital within a week or ten days. Of the ten patients still hospitalized as of March 1, 1946, four have been here between nine months and one year, while six have been hospitalized over one year. Each of these ten patients is diagnosed as psychotic, eight being diagnosed as dementia praecox and two as manic-depressives.

Due to the nature of the records kept, it was unfeasible to calculate accurately the exact progress in the hospitalization of each patient. The patients are transferred from ward to ward as their condition improves or relapses. For statistical purposes, the progress of the patients as a whole has been calculated by ascertaining the ward where the patient spent more than one half of his hospital residence. It was found that ten pa-

tients resided on the Acute Service (which includes disturbed, suicidal, and depressed patients) for more than one half of their residence here; five on the Continued Treatment Service (which includes parole, and semi-parole wards); seven on full parole wards; seven on the Infirmary Service; nine on the Reception Service; while ward residences of six were unknown, or could not be measured.

Of the group, a total of thirty-one had resided at one time or another on the Acute Service, while two of the patients still hospitalized have spent their entire hospitalization on a disturbed ward. Since the clinical picture, as well as the ward behavior, of these patients is constantly changing, and can fluctuate so widely, it was felt that no evaluation could be made of the general hospital adjustment of these patients from the information at hand.

TABLE XX

WARD RESIDENCE OF PATIENTS STUDIED FOR MAJORITY OF HOSPITALIZATION

Ward	Number	Per Cent
Acutely disturbed	10	22.7
Continued treatment	5	11.4
Infirmary	7	15.9
Reception	9	20.4
Full parole	7	15.9
Unknown	6	13.6
Total	44	99.9

Patients' Community Adjustments

The writer would like to discuss next the adjustment made by these patients once they returned to the community. To do this, Social Service reports on those patients out on trial visits were studied. For those out on discharge, questionnaires[6] were analyzed to determine their adjustment. Of the twenty-five patients who were discharged and received these questionnaires, ten replies were received. There has been correspondence with the Red Cross regarding an eleventh patient of this group (through our Social Service Unit) whose mother sought help from that agency after her son was discharged from this hospital. A twelfth patient, who has been readmitted here after discharge, has also been included in the evaluation of discharged patients' community adjustments.

In judging these adjustments, a "good" adjustment was felt to exist when the patient made a comfortable home and community adjustment, was feeling well, and either not drinking at all or not getting into difficulty due to his drinking. A "fair" adjustment was one when the patient was making only a minimal adjustment, was not feeling completely recovered, was not making a completely satisfactory adjustment at home, and whose drinking was causing some problems. A "poor" adjustment was one where the patient was perhaps still sick, still drinking and getting into trouble because of this, and was making an unsatisfactory home and community adjustment.

The ten patients still hospitalized were, of course, not rated in

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6 The questionnaires used in this paper were compiled for use in an unpublished thesis written by Mrs. E. A. Burr for Boston University School of Social Work.

this evaluation, since this considers the patient after he has left the hospital. Of the twenty-five patients discharged, five patients were making a good adjustment, three a fair one, and four definitely a poor adjustment. Thirteen cases were unreported.

Only one patient sought psychiatric help or advice. He applied to the Psychiatry Clinic. One sought help from Alcoholics Anonymous (See Case 6, p. 70) and has been helped by them. The mother of one patient sought help from the Red Cross voluntarily when her son began to drink heavily again. He was later referred to the Washingtonian Hospital for treatment by the Red Cross.

Of the four patients who were discharged, and reportedly made poor adjustments, one has returned to the hospital. This patient, a twenty-five year old man, has had five admissions for acute alcoholism between January 20, 1943 and October 7, 1946, three of which were in the period studied in this paper. He spent a total of ninety days here in that six month period, always on voluntary commitment. On his fifth admission, in October 1945, he was regularly committed and is still hospitalized as of this writing. He also carried a diagnosis of constitutional psychopathic state with mental deficiency. His inability to adjust socially is indicative of his psychopathic traits. At this time his case is presenting a difficult problem for the medical staff to handle, to achieve maximum benefit to patient and community.

The same criteria were used in evaluating the adjustment of patients out on trial visit. Of the nine who were on this status all but two received Social Service follow-up care, either from this hospital unit or

some other cooperating unit. Of these nine patients, no patient was reported as making a good adjustment, seven were making only fair adjustments while two were making decidedly poor adjustments. These latter two have been returned to the hospital from trial visit. Both of these patients were diagnosed dementia praecox, catatonic type. One patient had no social service follow-up at all, while the other had supervision by the Red Cross. (See Case 3, p. 64) The former remained at home for five months, the latter for less than three.

TABLE XXI

COMMUNITY ADJUSTMENTS OF PATIENTS STUDIED WHO WERE OUT ON TRIAL VISIT OR DISCHARGE

Adjustment	Discharge	Trial Visit	Total	Per Cent
Good	5	0	5	14.7
Fair	3	7	10	29.4
Poor	4	2	6	17.6
Unknown	13	0	13	38.2
Total	25	9	34	99.9

Note: The reader may be interested in comparing this Table with Table XV, p. 44.

Social Service

To give the reader some idea of the type of supervision and follow-up given to patients on trial visit by hospital Social Workers, two interviews are presented from a case of a patient on trial visit with his mother since October 21, 1945. His diagnosis is psychoneurosis, anxiety type; psychosis intoxication alcoholic, acute hallucinosis, recovered from, and

chronic alcoholism. This case is also presented in detail in the Case Analysis. Case 5, p. 68.

1/18/46 Patient and his mother interviewed in home visit. Financial stress has been an area of concern for patient and mother since prior to service, he was the one who had always taken financial responsibility. Patient's mother is well on in her 70's, has been fearful about patient's condition and worried about his desire to drink, although patient minimizes his need to do so at this time. Since patient has not yet been in receipt of compensation checks, referral was made to Soldiers Relief as a resource at this time. Patient is not yet ready to take employment and is therefore not eligible for any readjustment allowance at this time.

He has no somatic complaints, says that he has been eating and sleeping well, but because he was still fearful of having to return to the hospital was attempting to cover up many of his symptoms. Mentally he is clear, though there seems to be some deterioration of will and some unsteadiness in patient's gait. Patient reads and gets out to the movies and has put on some weight since leaving this hospital. Patient seems to be rather passive and dependent, and had to be helped in filing dependency claims with the Regional Office.

3/1/46 Social Workers visited patient at home. Patient's mother has been extremely anxious because patient's compensation was rated at 10% disability. There is no other financial resource. Their room rent is $9. a week, and is the only thing which they were able to find, though this is on a much lower standard of living than that which they had been accustomed to in the past. Patient is in poor physical condition, and although he talks about wanting to go to work has shown no initiative in this direction, and from all appearances it would not seem that he would be able to hold a job at this time.

Patient stated that he has not been drinking a great deal, but since today is his birthday he was treated with a glass of beer by a friend of his in the neighborhood. Patient was limping, although he tried to conceal this when he opened the door for Social Worker. When questioned about it, he stated that the heel of his left leg was painful and that he suffered some slight weakness in the lower part of the leg. His gait is somewhat unsteady and spastic. There is evidence of some physical deterioration, and the patient looks considerably older than his years. Mentally he is not confused, volunteered conversation, but seems to have shown considerable regression. He has been trying to review some of his mathematics, and spoke intelligently about his work as a surveyor and as structural draftsman, which he would like to try again. The latter type of job would probably be feasible, since the patient could do his work sitting down.

Patient is an intelligent person and responds to warmth and understanding, and has inferior feelings about not having accomplished a great deal in his life. Patient tries to be on his best and to impress worker favorably, requesting that she turn in a good report to the Medical Staff, because of his fear of future hospitalization. Although his adjustment seems adequate enough to remain on trial visit, it is only on a minimal level, and bears watching.

Since patient's health at this time does not seem amenable to employment, interpretation regarding giving Power of Attorney to one of the Service Organizations and requesting review of his case was given, and patient expects to follow through on this. Patient was informed about Miss Coppak in the Vocational Handicap Division, at the USES, and will make contact with her in an attempt to obtain some sort of limited employment to test his own ability.

Since patient's mother displays a great deal of anxiety about the financial stress and patient, an early visit will be made to talk with her and patient again.

This case is presented for it depicts some of the more or less typical situations met by social workers at this hospital. Present are anxiety over financial problems relative to compensation and pensions, apprehension regarding the patient's mental health and adjustment, fear of being rehospitalized, and doubts about future vocational plans. These are stressed while the patient's drinking habits are minimized.

The worker's role in the interview can be seen as that of giving support, warmth and acceptance to a patient who is obviously insecure, and whose ego is weak and in need of reinforcement. She is also able to help him direct his energies into constructive channels, by use of the USES Vocational Handicap Division. She also gives him information regarding his pension, and plans to be re-rated. Just how successful she can be in helping the patient abstain from drinking heavily is something that cannot be seen from these interviews. She does recognize his deterioration, however, and is prepared to deal with the patient on the level at which she finds

him.

Social Service Treatment Policies

A new policy has been instituted among the Social Service Staff since the material for this paper was gathered. It is now a policy to discuss referral of all alcoholic patients leaving the hospital on trial visit, or being discharged, to Alcoholics Anonymous,[7] a group organization designed to help chronic alcoholics stop drinking. The case load carried by each worker at this hospital is frequently so large that it necessitates that any work done with patients still hospitalized is on a more or less short contact basis. In addition, the amount of time that a patient is hospitalized may not be lengthy enough to lend itself to any but a comparatively few interviews. In this time, the social worker must establish her relationship, make her diagnosis of the case and institute her treatment of the patient. If she is treating a patient who is out on trial visit, this is also true, for though she may have a longer period in which to work, she must be ever mindful of the fact that she must accomplish as much as she can before the patient begins to slip back into his illness or drinking patterns. This is in addition to the fact that her case load may be so extensive as to make weekly or semi-monthly contacts with each patient impossible.

The use of Alcoholics Anonymous by the hospital workers and psychiatrists is significant because it indicates that they are not afraid of admitting that their own treatment facilities are over-taxed, and they are perfectly willing and eager to use a community resource which has proved

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7 See Alcoholics Anonymous, written by Alcoholics Anonymous members

helpful in the past. At this point the results of the extensive use of Alcoholics Anonymous cannot be evaluated as this is a comparatively new procedure. We can look at it optimistically, however, the writer feels, as being something of a "last resort", in many cases, for some of these patients who apparently do not respond to therapy from a psychiatrist, or a social worker, but who seem able to garner sufficient strength from Alcoholics Anonymous to help themselves.[8]

Alcoholics Anonymous is a welcome organization, but, unfortunately, cannot be utilized by all patients. Some are too psychotic to be able to take advantage of it. Others simply refuse to accept any help at all, and spurn referral. How can social service help these patients when they return to the community? In both cases, the worker can try to find the patients strengths and attempt to emphasize them, with the hope that this will help the patient to make his adjustment. In any event, treatment with such patients is extremely difficult, particularly in the case of the alcoholic who will not admit that his drinking is injurious or excessive, and who stubbornly refuses aid. Such a patient cannot form a workable treatment relationship, and certainly cannot benefit from treatment until he is willing to cooperate.

It is possible, too, for the worker to manipulate the environment in such a manner as to assist the patient to make his adjustment. For instance, a patient who drinks because of an unhappy marital life might be helped if he could live alone, with friends, or his family. The workers

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8 For an example of this, see case 6, p. 70.

make plans for patients, when necessary, when they leave the hospital, and it is here that a skilled worker may use her knowledge of the benefits of a change of environment to help a patient.

CHAPTER VI

CASE PRESENTATION

In selecting cases to discuss, the writer has chosen six cases felt to be more or less representative of the sample from which this study was made. As all of these patients are veterans, and as their military service was such an important factor in their life and future modes of adjustment to the community, it was decided to select military service as the point of differentiation in the selection of cases.

Six cases, therefore, have been chosen in the following manner: two cases of patients who did not adjust well prior to their induction into service, whose previous personality difficulties were serious, and who had breakdowns prior to their military service. These cases comprise the first category.

The second category represents patients who broke down seriously while in service, and is made up of two cases.

The third category is made up of two cases who broke down seriously after their discharge from service.

In each category, one case was selected depicting a patient who is still making only a minimal, or poor, adjustment, and one case was chosen representing a patient who has improved and who is making a good adjustment. In the first category, however, no case could be found of a patient who had been hospitalized for a breakdown prior to his military service, and who was now making a better adjustment. Accordingly, a case was selected in which the veteran made an unsatisfactory home and community adjust-

ment, before the war, without having been hospitalized, and is now making a more satisfactory adjustment than before. (See Case 2, p. 62)

GROUP A. PATIENTS WHO BROKE DOWN PRIOR TO MILITARY SERVICE.

Case 1. A Patient Who Still Does Not Adjust.

Mort is a thirty-year old patient whose diagnoses at this hospital was Psychosis, Post Traumatic Personality Disorders; Alcoholism Chronic. He was admitted here from a State Hospital in April of 1945. His family history is interesting, in that his father and grand-father each were patients at this same State Hospital, each for excessive drinking. Mort's parents separated when he was a youngster, due to the father's excessive drinking, and Mort lived with his mother. He has a twin sister and also two younger brothers and three younger sisters. Their family relationship is not known.

Mort was a dull child and slow in school, leaving the sixth grade at fifteen to work. He did odd jobs, usually of a clerical nature, his income being only marginal, his adjustment fair. He was a quiet, shy fellow, rather nervous, and eneuretic until six. He preferred the company of men to that of women, although he occasionally dated girls. He denies any homosexual acts, however.

He began to drink as an adolescent, but his drinking was not excessive until about three years ago, after his discharge from service, and has been severe ever since. His excessive drinking allegedly began when he tried to relieve severe headaches with drunkenness. These headaches date back to 1935 when he had a skull fracture and was unconscious for four days. Shortly thereafter he began developing headaches, some delusions, and hallucinations, and difficulty in concentrating. He was able to make a marginal adjustment, however, until January of 1940 when he became resistive, assaultive, and was hospitalized in a State Hospital. After a course of metrazol treatment, he improved and was given a trial visit in August of that year.

He enlisted in service directly after leaving the hospital in September, 1940, and served only in this country. His adjustment to service is not known, however. He was discharged in March, 1942, with a Medical Disability.

He then returned home, lived part of the time with his mother, partly with a married sister, but his drinking became so obnoxious, his behavior so belligerent, that they feared him. He was restless, changed jobs frequently, spent most of his money for liquor. This pattern continued until December of 1944, when he was re-admitted to the State Hospital where he was manneristic, confused, hallucinated and deluded. He was transferred to this hospital the following April.

Here he was well-oriented, neat, clean, cooperative, accessible,

had no hallucinations or delusions, had fair insight, and blamed all of his trouble on his heavy drinking. He made a good ward adjustment and was transferred from the admission ward to a full parole ward in less than a month, and was discharged completely after eighty days of hospitalization.

He has married since his hospital discharge and he and his wife now live with his father-in-law in North Carolina. He does some farming, but little work, living mostly on his government pension. He feels only fair, complains of not being strong, and still drinks on occasion when bothered by headaches.

Case Analysis.

This is a patient whose early adjustment was marginal until, in 1935, he received a skull fracture which resulted in a post-traumatic psychosis and a gradual downhill course in adjustment and behavior. His family history, however, is poor, including an alcoholic father and grandfather, both of whom required hospitalization. His parents separated because of this alcoholism, and it is found that later, when troubled by headaches, Mort tries to seek refuge in alcohol and drinks excessively.

His pattern of behavior when he drinks excessively is assaultive and dangerous to others. However, he does seem to be able to gain insight into his condition when his episode is through. At this time he is feeling only "fair", he is living a decidedly dependent existence, both on the government for a pension and on his father-in-law for employment. The prognosis in this case is dubious, in view of the past history. Just how good an adjustment he can make, even without drinking, is unpredictable, but should he begin to drink again excessively, his adjustment will probably take a downhill course again.

Case 2. A Patient Who is Making an Improved Adjustment.

Tim is a forty-one year old, single, patient, who was diagnosed as Psychosis with Psychopathic Personality, Psychosis Improved;

Alcoholism Chronic. He was admitted to this hospital in January of 1945, directly from an Army hospital.

His family history is essentially negative. His father died when the patient was thirty-one, his mother when Tim was twenty-three, and of the eleven children originally in the family, he now has four brothers and one sister alive. The record describes him as being sociable, good natured, gentle, and athletic. However, he was never able to make a satisfactory job adjustment, having held several jobs before service, the longest being when he worked for a year repairing machinery. He also worked in a shoe factory, as an ice and coal deliverer, and was a truck driver. His school adjustment was only fair, and he quit after the eighth grade to go to work.

Tim's smoking and drinking habits have been excessive for some time, and he started to drink as an adolescent. He gets drunk on a few drinks, and used to make a practice of getting drunk every week-end. During the past ten years, however, he has tapered off somewhat in his drinking, although still drinking heavily. He has a rather formidable court record, having been arrested eleven times between 1926 and 1937, with seven arrests for intoxication, two for petty larceny, and two for stealing automobiles. He admits that he drinks excessively, and blames his drinking for his inability to adjust, and for his arrests, as each time he committed a crime he was drunk. He has also served two sentences in the House of Correction, once for eight months, once for one month.

Tim's sexual pattern is that of shying away from girls, whom he has "never dated", as he prefers the company of the same sex, although he denies now having had any homosexual experiences. He is said to have confessed to these while in service, but now states that he made these stories up to get out of service.

He was drafted into the Army on August 5, 1942, and served as a Private until his discharge at this hospital in January of last year. His military adjustment was poor, having served several company punishments for both intoxication and lack of attention to duty. He served in New Guinea for almost twenty months, however, and though not in actual combat, was subject to bombing attacks.

While overseas, his conscience bothered him about some alleged homosexual acts. He became vague, preoccupied, panicky, thought others were trying to prove him a homosexual. He heard voices, was depressed, retarded, apathetic, and was transferred to the Zone of the Interior. At an Army hospital here he was still hallucinated and seclusive. He was given ten insulin shock treatments, with no improvement. He then became suicidal, thinking the future hopeless.

When admitted here, however, he was quiet, somewhat depressed, emotionally flat, but expressed a strong desire to return to work. He admitted his heavy drinking and his insight and judgment seemed good. He was not actively hallucinated or deluded. His ward adjustment was good, though at first he was seclusive and seemed preoccupied. In eleven days he was transferred from the Reception Service to a semi-parole ward, and was discharged from that ward as improved after being hospitalized for eighty-eight days. When discharged,

the Staff felt that it was difficult to know whether he was actually homosexual or not, and felt that there was a strong element of dementia praecox present.

At present he is living with a younger brother, and supporting the latter by working as a boilermaker. He works steadily and makes a good salary, having started to work two weeks after his discharge from this hospital (April, 1945) and getting his job through a union. His work is seasonal, but he reports that he plans to save money for the slack season. His adjustment now can be considered most satisfactory, and he is not having any known difficulty with his drinking.

His only Social Service contacts were given when he was discharged, as far as is known.

Case Analysis.

Tim is a patient whose early adjustment picture is somewhat representative of a psychopathic personality, with his inability to adjust on the job, changing jobs frequently, and numerous arrests. Yet the question arises, as it did to our Staff, whether there might not be some schizoid mechanisms present too. The fact that Tim has been able to make a satisfactory adjustment now makes one wonder if he is a true psychopath. He does seem to have insight into his condition, and thus far has been able to have sufficient strength to stop drinking. It is not known if he is actually a homosexual, nor is the meaning that this might have to Tim indicated. Its effect is strong, however, as seen by the fact that this homosexuality was so predominant in his delusional trends.

GROUP B. PATIENTS WHO BROKE DOWN IN SERVICE.

Case 3. A Patient Who Still Does Not Adjust.

Joe is a thirty-eight year old, single, patient, who was admitted to this hospital directly from an Army Neuropsychiatric Hospital in April of last year. He was given the diagnosis of Dementia Praecox, Mixed Type.

Joe's family history is significant, in that his mother has been hospitalized in a State Hospital since 1931. Joe's father is described by his neighbors as "queer" and "dumb", though he has never

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been hospitalized. Joe's siblings are unknown. He finished one year of high school at fifteen, making only a marginal adjustment scholastically and socially there. He is described as a quiet, rather shy boy, not overly friendly, unobtrusive, but capable of eeking out a marginal existence for himself. Before the war, he worked as a factory hand for two years, and then did odd jobs as a construction worker, making only a minimum economic adjustment.

Joe has a lengthy history of drinking, having started to drink to excess in adolescence. He has been arrested numerous times on charges of intoxication. In 1937, while he (Joe) was drunk, a friend of his was accidentally electrocuted, and Joe reportedly felt a great deal of guilt about this.

He always preferred to live a secluded life, and never tended any serious thoughts of marriage, although he has denied homosexual tendencies and has made a heterosexual adjustment.

Joe was inducted into service on February 17, 1942, and made an adequate adjustment there, serving as a Private with the Engineers. He served in the ETO from June of 1942 until December of 1944, and saw a great deal of combat, taking part in two invasions in Africa and Italy. Just prior to the onset of his illness, a very close buddy of Joe's was killed before his eyes when a mine exploded in the battlefield. Joe then began to develop a similar guilt reaction to the one he had when his friend was electrocuted. He gradually developed ideas of reference, thought people were accusing him of being "vile", was extremely depressed, and actively suicidal. He was transferred to the United States, and on showing no improvement at an Army Hospital was transferred here.

Here he was admitted to the suicidal observation ward, where he displayed extreme guilt reactions about his buddy's death. He thought that people were reading his mind, and was remorseful and quite paranoid. This gradually began to clear, however, and within five months he was given short leaves of absence at home, where he made a fair adjustment. He left on a Trial Visit on November 9, 1945.

While at home, his case was followed by the local Red Cross worker. At home he was reported as being secluded, reclusive, obviously hallucinated and deluded and drinking heavily "to forget". He lived alone in a dilapidated shack near his father, who also lives in a shack. Joe was getting only slip-shod supervision, and no psychiatric guidance, other than the assistance given by the untrained Red Cross worker. He gradually began to go downhill, had no interests, hobbies, work, etc., and finally began developing various somatic delusions, for which he would torment neighboring hospitals and doctors, requesting that he be given a plate in his stomach. His psychotic behavior gradually increased, until he was returned to the hospital in February of 1946 at the behest of the Red Cross. He protested his return saying there was nothing the matter with him. Here he was admitted to the semi-acute service, but was transferred to a semi-parole ward in less than a month.

Case Analysis.

In Joe's case, one sees a boy who made only a marginal adjustment before service, but who managed to get along. The reasons for his heavy drinking are not directly apparent, but a strong element of guilt seems to be operating in this case, and the dynamics of this reaction cannot be overlooked in evaluating Joe's drinking habits, as well as the development of his illness. At home, in his community, his adjustment is poor; he gets little, if any, supervision, and is left on his own with nothing to occupy his mind. From his reports, the Red Cross worker earnestly tried to give help in this case, but confesses that he is untrained and is perplexed by having to deal with an obviously psychotic patient. Continued psychiatric guidance seems to have been needed in this case, or skilled case work, to sustain this patient in the community. The patient's present hospital adjustment seems encouraging, and considerable guidance from Social Service will be needed to plan for this patient's return to the community.

Case 4. A Patient Who is Making an Improved Adjustment.

Ted is a twenty-three year old, single, patient who carries the diagnosis of Dementia Praecox, Paranoid Type, and who was admitted to this hospital directly from the Army Hospital in July of 1945.

His family history does not seem significant. His mother died at fifty-six, his father is still alive. There is no known history of mental disease, or alcoholism. Ted was the second of three children having one brother and one sister. His personality make-up, however, is rather significant, in that he was eneuretic until thirteen, was always a nail-biter, was quiet, shy and rather retiring as a youngster. He was always nervous in large crowds or in noisy places. His school adjustment was good, however, and he attended one year of trade school after finishing grammar school. Before the war he was a welder in a shoe factory, and was a steady, conscientious worker, who adjusted well on the job.

Ted has been drinking to excess since he was sixteen, and was arrested once for alcoholism. His drinking, however, never interfered with his work.

Case Analysis.

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Ted has been drinking to excess since he was sixteen, and was arrested once for alcoholism. His drinking, however, never interfered with his work.

He has had no sexual experience of any kind, and denies having homosexual tendencies.

He enlisted in service in December of 1942 and served in North Africa and Italy, where he was in active combat with the infantry for over four months. His army record is good and his adjustment satisfactory. His mother died while he was overseas, however, and he had a great deal of feeling and strong grief because of this. While in Italy, after having been wounded, he contracted yellow jaundice, and was hospitalized for this. He then became withdrawn, seclusive, retarded, and was diagnosed as "Anxiety Neurosis". Later he became confused, heard voices, and was diagnosed as "Psychosis, Unclassified", and transferred to the United States. At an Army Hospital, he remained on a closed ward, was actively hallucinated, and heard voices telling him to do bad things.

When admitted here, he was confused, agitated, bewildered, restless, and was in restraint, tubs, or packs for a total of 280 hours. He was given a course of seven electro-shock treatments and improved. Thereafter he worked on the ward kitchen and made an excellent hospital adjustment. He spent four months on the suicidal observation ward, one month on the semi-acute service, from which ward he was given first a leave of absence, which was then extended into a trial visit beginning in July, 1945.

The patient's father, a disabled World War I veteran, lives at home with the patient and has some insight into Ted's condition. His sister is also present at home, and our social worker who is supervising the case, felt that the family group was close and that Ted would be getting good supervision from the family.

Ted tried to work at his old job at first, but found it too strenuous, so he took a lighter job in the same factory as a general helper and janitor. He makes twenty-five dollars weekly and is allowed to rest when tired. He has little responsibility in his job, and has shown considerable improvement in his condition. He gets along well, seems more friendly and outgoing, and has stopped drinking completely. The somatic complaints and battle-dreams which he had when he first returned home are gradually disappearing, though he is still somewhat restless. In general his adjustment is good, and he seems to be capable of getting guidance from the case worker.

Case Analysis.

Ted is a patient who was always shy, retiring, and a nervous child, but who managed to make a fairly good adjustment at home and at work. His drinking began when he was only sixteen, and was excessive since, though it did not interfere with his work. His adjustment in service was good, until following a four month period of combat, at which time he developed jaun-

dice after being wounded. This was followed by a neurotic anxiety reaction, which later developed into a psychotic breakdown. He reacted favorably to a course of shock therapy at this hospital, and was able to leave on trial visit after being hospitalized here exactly five months. His adjustment at home is good, despite the grief he still has for his deceased mother. He is getting good family supervision, and though his economic adjustment is on a lower level than before the war, his social and community adjustment is satisfactory. He is also receiving sustaining case work from the hospital social worker. As Ted has not yet been out a year, his case will still bear watching to try to forestall any relapse he might yet suffer.

GROUP C. PATIENTS WHO BROKE DOWN AFTER SERVICE

Case 5. A Patient Who Still Does Not Adjust

Bill is a forty-five year old, single veteran who was born in Newfoundland and who came to this country when twenty-seven. He is diagnosed as "Psychosis Intoxication Alcoholic, Acute Hallucinosis; Psychoneurosis, Anxiety Type". He was admitted here in March of 1945, from his home.

Bill's father died when he (Bill) was only four, following which his mother remarried within a year. Bill's step-father died when the boy was only seven. Bill had another death in his family when his younger sister died at eighteen leaving only Bill and his mother.

He started school when four and was a good student, getting his B.S. following which he studied for five years for the priesthood. He left this, however, feeling at the time that he was not cut out to be a priest. He now has a great deal of feeling about leaving the priesthood, saying that he was a "quitter". His first job was as a surveyor, which work he did well for ten years, following which he started doing drafting, painting and other odd jobs. He was a jolly, happy-go-lucky fellow, with a pleasant disposition, sociable, and a good mixer. He liked people and got along well with them.

He drank in moderation since a boy, as it was part of the cultural pattern in which he was brought up, but he never drank heavily until he went into service. He then began drinking "on and off" for a period of eighteen months, and drank especially heavily when he got "down in the dumps". He had been drinking heavily prior to his

hospitalization.

Bill had gone frequently with girls, but always broke off just before the relationship became serious. He is quite devoted to his mother, who is an elderly woman, and quite dependent on her. Bill denies any homosexual trends, and says that one reason for his giving up the priesthood is that he felt that he could not hold to the chastity vows.

He was inducted into service in October 1942, where he made a good Army adjustment. He reportedly enjoyed Army life where he served as an anti-tank gunner. He was injured while on manoeuvres in October 1944, and was later returned to duty. Two months later, however, he was discharged with a 10 per cent disability for "Anxiety Neurosis", after being hospitalized in a Station Hospital because of his "nervousness". There, he expressed a great deal of guilt about leaving the priesthood, and on discharge from the Army this guilt was reinforced by added feeling about his disability discharge, as he wanted to remain in the service.

Once home Bill became depressed, felt that he had failed in service. He had no home to return to as his mother had given up their home when he was inducted. She was living with relatives and he roomed nearby until they found a flat, some months later. He was nervous, did not eat or sleep well, in four months did no work at all and gradually became worse. His drinking, which was getting fairly heavy in service, now became excessive. He then developed some hallucinations and delusions, and was brought to this hospital by a private physician.

Here he spent most of his hospitalization on the infirmary ward, after having had a grand mal seizure. He had three such seizures while here. After four months on the infirmary service, he went to a semi-parole ward where he remained quiet, cooperative and minimizing his past drinking. When given a twelve hour pass and warned not to drink, he drank anyway. He left in October, 1945 on a trial visit.

The social worker, who had obtained a social history from the patient's mother, now followed the case when Bill returned home. She reports that he is forgetful, still drinks occasionally, and complains of not being able to work yet. He spends most of his time visiting and "hanging around". His adjustment is poor, in comparison with his early life's history and education and capacity.

Case Analysis.

Bill is a veteran who started out in life making a good adjustment, but who has been gradually deteriorating for the past ten years. He had an extensive education, and is quite intelligent. His habit pattern seems to be one of not seeing a thing through, as illustrated by his having given

up his priesthood, his career as a surveyor and his habit of breaking off with girls before becoming serious. He also has a great deal of guilt regarding his failures or misdeeds. His background also reveals a history of three traumatic deaths, his father, step-father, then his sister, each of which must have held some deep meaning for the patient.

Though he drank before service, he was not an actual alcoholic until he entered service. While in the Army he developed an anxiety neurosis, which seems to have stirred up a great deal of guilt, after which his alcoholism rose sharply eventually culminating in his hospitalization here. He is being followed by our Hospital social worker, upon whom he seems rather dependent.

Case 6. A Patient Who is Making an Improved Adjustment.

Jack is a forty-two year old, married veteran, who was admitted to this hospital in March, 1945, from his home. His diagnosis reads: Alcoholism Acute, Recovered From; Alcoholism Chronic.

His early history is essentially negative. His parents are still alive and neither drinks. Jack is the eldest of four children, having a brother and two sisters. His brother reportedly "drinks moderately". Jack was an excellent student, and was graduated from a top Eastern college with an excellent record. He was a diligent student and serious minded. He worked his way through school, and so had little time for fun or dates, although he always enjoyed both.

After finishing school, he joined the faculty of the college and was an instructor in journalism, and a faculty advisor to students. He later became an accountant, and worked at this for three years. During the depression, his luck was low and he took a job as a deck hand on a tramp steamer, stopping off in India to tour the country. After this, he had several other odd jobs, and finally worked with his father, who was in the real estate business.

Jack first began drinking at twenty-three, but only in moderation, and it did not "bother" him until 1940, since when he has drunk to excess, his drinking affecting his work. He drinks, he says, as a "flight" from disgusting or upsetting conditions. Before hospitalized here, he gave as his excuse for drinking the fact that his job was too hard and to escape from a difficult family situation. At that time he was living with his father-in-law and his wife's girl friend, a situation which he found distasteful and from which

he tried to escape. He and his wife planned to move, but never quite got around to it.

He married his wife in March of 1943, his wife being two years his senior. There are no children, and their marriage relations are described as "congenial".

Jack was inducted into the Army in November of 1942 and made a good adjustment in service. He did light office work, and though he drank in service it was not to excess. He was discharged in December, 1944, for "Chronic Bronchitis".

Three days after his discharge, he went on a "bender" and could not stop drinking. He was finally hospitalized at a private hospital for one week and was later sent there five times between December, 1944, and February, 1945, for acute alcoholism. Finally in February he got a job as an office manager, but began to drink in March after work, and after one week of steady drinking was unable to work. He was admitted here, intoxicated, and remained overnight, refusing to commit himself. He left the following day vowing not to drink, knowing he only wanted to get out to get a drink. Returning home he was restless and, on not finding any liquor in the house, drank rubbing alcohol. He was readmitted here, the following day, drunk. He had no delusions, hallucinations, his memory, judgment and insight were good.

Here he was admitted to the disturbed ward with "impending d.t's", he was shaky, tremulous, restless. He quieted down and was transferred to the Reception Service within four days, where he remained for another twenty days, finally being discharged from the hospital after twenty-four days.

Once home he made an excellent adjustment. He and his wife now live alone, and he is working as an accountant where he is making more than before service. He is also studying accountancy under the G.I. Bill. Most important of all, however, is that he has relinquished alcohol completely and has become a star member of the "Alcoholics Anonymous", which he joined of his own volition. He is eager to make a fresh start, make a good adjustment and help others who are afflicted with alcoholism. His general social, economic and community adjustment are excellent.

Case Analysis.

Jack was a serious minded, conscientious young man, whose early life adjustment was good, his background excellent. Starting with the depression, however, he gradually began slipping down-hill, and his drinking, which began at twenty-three, gradually increased. He used alcohol as an escape from difficult or unpleasant situations, and finally, after service, his drinking culminated in a prolongued debauch with five hospitalizations

in private hospitals.

After a short hospitalization here, he joined Alcoholics Anonymous, finding that they could help him after he himself sought help. His adjustment now is excellent, his prognosis good, in view of his previous good background and strengths, plus the additional strength and help he gets from "A.A."

CHAPTER VII

SUMMARY AND CONCLUSIONS

This thesis was undertaken to make a study of the incidence of alcoholism among the veterans of World War II admitted to a Veterans Hospital over a six month period. A general survey of common factors in the lives of these particular veterans was made to try to observe what, if any, common factors were present in the lives of these men who are so predisposed to rely on a narcotic, alcohol, to escape from reality.

No attempt was made to try to determine just why these men turned to alcohol as their means of escape, as this area is one which belongs to the psychiatrist. This paper was rather concerned with the social, community, and military adjustments of these men before, during and after service. It was also concerned with their early development and some factors present in their early lives, as well as the effect that their military service may have had on their drinking.

The group selected for study was chosen from the 416 admissions to a Neuropsychiatric Hospital during the period of January 1 through June 30, 1945. The cases studied were chosen because they carried one of a variety of alcoholic diagnoses, or because their drinking had been so heavy in the past that it appeared significant in the etiology of their illness and the onset of their psychoses.

An attempt was made to define an "alcoholic" and to depict the relationship between the psychoses and alcoholism, as well as to depict some examples of the wide variety of thinking prevalent in this entire area.

CHAPTER VII

SUMMARY AND CONCLUSIONS

It was found that most authorities believe that there is no common personality which will predispose a person to being an alcoholic, and the factors contributing to one's developing into an alcoholic are as widespread.

Some description was given of a Veterans Administration Neuropsychiatric Hospital and of the functions of the Social Work Unit in such a Hospital. The rules regarding discharge and trial visit were presented, as well as the rules governing commitment to the Hospital.

The diagnoses of the group were studied, and it was found that 38.7 per cent carried a diagnosis of a psychosis, such as Manic-Depressive Psychosis, or of Dementia Praecox. While 38.6 per cent carried alcoholic diagnoses, the remainder of the group was diagnosed as with a number of non-psychotic diagnoses, or post-traumatic personality disorders. Several patients carried more than one diagnoses, and these figures were also presented.

The average age of these patients was found to be thirty-one, while 59.1 per cent of the group are in the twenty-five to thirty-five age bracket. The average time of hospitalization before a patient was discharged was 27.5 days, while a patient remained in the hospital an average of 161.5 days before leaving on trial visit.

In studying the backgrounds of these patients, it was found that none had an alcoholic mother, or an alcoholic mother and father. Twelve patients, or 27.3 per cent, did have an alcoholic father. Due to the scanty collateral information, however, no broad conclusions could be drawn from this data as to whether this indicates that heredity or environment is important in the development of an alcoholic, or if it is due to

father-identification, neglect by a mal-adjusted parent, or one of a number of other possible suppositions.

The same holds true in regard to mental illness in the parents of these patients. In this instance, however, it was the mother whose maladjustment was preponderent, with seven patients having mothers who were hospitalized in mental hospitals.

In order to try to make a general evaluation of the childhood adjustment of these patients, their early school adjustment was studied and rated as being "good", "fair", or "poor". The data indicated that eighteen, or 40.9 per cent, were making a poor adjustment in their schooling, while 63.6 per cent made a poor, or only fair adjustment. Again the data was not sufficient to indicate the exact causes for these poor adjustments at school, and it cannot be said definitely that it was due to a lower intelligence, a poor home adjustment, or the beginning of their general inability to adjust to life and the reality situation.

The drinking habits of these patients was also studied, as to the number of years they have been drinking and the ages when they began to drink. It was found that only four patients (9 per cent) had been drinking for three years or less, indicating that but for these four patients, all had been drinking excessively since before their period of military service. Almost one-half of the group, 49.9 per cent, began to drink between the ages of fourteen and twenty-five, and one patient began his alcoholic career at twelve.

The incidence of homosexuality among the group was also studied. It is believed that this tendency is often common among alcoholics, and in

father-identification, neglect by a mal-adjusted parent, or one of a number of other possible suppositions.

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The incidence of homosexuality among the group was also studied. It is believed that this tendency is often common among alcoholics, and in

this group it was found that nine patients, or 20.4 per cent, had had some overt homosexual experience. The sex tendencies of eleven patients were unknown, however, and this might have changed these statistics. It must also be remembered that this is an area in which the patient, or family, giving the history might not be truthful in giving information, or in the case of the family such tendencies might be unreported because they are unknown to the family.

The majority of the group, 63.6 per cent, are single, twelve patients are married, and four patients are separated and divorced. There is a marked tendency toward a marriage where the wife is from one to ten years older than the patient, as was the case in six of the twelve patients who were married. Their mental adjustments, on the whole, were unstable, particularly after the onset of their illness or increase in their alcoholism.

The majority of these patients represent the class of unskilled workers, with twenty-five patients, or 56.8 per cent, being such. Twelve patients are skilled workers (27.3 per cent). It cannot be concluded from our data whether this reveals the results of a cultural pattern wherein laborers and unskilled workers drink heavily, or whether it is because alcoholics and other patients coming from the higher income brackets might go to a private hospital for treatment. Farmers, students and professional workers are represented by one patient each.

A comparison was made between the general pre-war adjustment of all patients and the community adjustment of those patients out on trial visit or discharged. It was found that before the war eight patients, 18.2 per cent, of the group of forty-four studied, were making good adjustments.

Twenty were making fair adjustments (45.4 per cent) and ten poor adjustments (22.7 per cent). Six patients' (13.6 per cent) adjustments were unable to be evaluated due to lack of material.

Of the thirty-four patients out of the hospital on trial visit or discharge, only five (14.7 per cent) were making a good adjustment, ten (29.4 per cent) a fair one, while six (17.6 per cent) a poor adjustment. Thirteen patients (38.2 per cent) were unknown. In the latter instance, due to the large percentage of cases which were unreported, or unknown, and the small size of the sample, no conclusions can be drawn about the general adjustment of this type of patient in the community. It is felt, however, that if these thirteen patients had replied, the figures would have been larger in the poor or fair categories, rather than the good adjustment category.

The military service of these men was scanned, and it was found that the bulk of these patients (77.2 per cent) served from six months to three years in service. Their adjustment there was rated and it was found that seven (15.9 per cent) made a good adjustment, seventeen (38.6 per cent) a fair one, and eleven (25 per cent) poor adjustments. Nine patients (20.4 per cent) were unreported. Twelve of the group, or 27. 3 per cent, were in active combat duty. Of these, six broke down during, or directly following, combat duty. Six did not require hospitalization until after their return to civilian life. Ten of these twelve patients were diagnosed as psychotic, two as without psychosis.

In examining the role played by social service in the treatment and diagnosis of these patients, it was found that, for the most part, social

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In examining the role played by social service in the treatment and diagnosis of these patients, it was found that, for the most part, social

service was inadequate in the cases studied. No patient received the complete services of the social work unit, due mainly to the fact that during the period covered in this study that department was severely understaffed. At the time of this writing, the unit is not only being enlarged with trained personnel, but their policies in regard to the disposition and treatment of alcoholic patients are in the process of revision and enlargement. As was pointed out, Alcoholics Anonymous is not being used in a great many cases for it is felt that this organization can do much in the rehabilitation of those cases where the psychiatrist and social worker have met only with failure.

In this respect, it can be noted that many of these patients are simply unable to form the relationship with the therapist, be he psychiatrist or case worker, so necessary before treatment can be undertaken. Once, however, the therapist can get the patient to accept help from Alcoholics Anonymous, he is often able to benefit rapidly from the help they have to offer. Unfortunately, this program was not used extensively during the period this thesis covers, so no evaluation of its effectiveness could be made. One patient did seek out Alcoholics Anonymous, however, with startling results and a rapid recovery.

The writer feels that with an increase in the staff at the hospital both Medical and Social Service, as well as an increase in the use of community resources, such as Alcoholics Anonymous, Psychiatry Clinic and Family Agencies, better results can be obtained in the general rehabilitation of these families than were attained before. Hospital authorities are still confronted with the problem of whether or not the "pure" alcoholic,

that is, the one who is not actually psychotic, rightfully belongs in a mental hospital of this type. At this time, he is still eligible for admission, but presents a problem in treatment and rehabilitation which is far more difficult to solve than those of most psychotics.

The social worker can be of assistance in these cases in getting complete history material for these patients in order that correct diagnoses may be made for each case, and also to help in forming both her own, and the psychiatrist's, treatment plans. She can also help in evaluating the home situation before the patient leaves, and can help in settling any family or environmental difficulties which may arise. Her role in actually treating the patient depends largely upon her own skill, the treatability of the particular patient, in addition to the time factor. Given a skilful worker, a patient anxious to be helped and sufficient time to carry on the necessary interviews and good results can be anticipated.

In most of the cases studied, however, either the case work service was rejected by the patient, or he was unable to use it; the worker was untrained; or there was not sufficient time in which to carry on treatment. The results, therefore, were poor. Case work does have a service to offer these patients, the writer feels, and the test of this will come in the near future when social workers will be given their full measure of responsibility in helping the patient, and when they will have the staff with which to function smoothly.

Approved,

Richard K. Conant

Dean

APPENDIX A

SCHEDULE USED

Name: Marital Status: Diagnosis:

State: Occupation: Admission Date:

Age: Total Hospitalization: Discharge Date:
Trial Visit " :

MILITARY HISTORY
Date Inducted:
Date Discharged:
Rank and Service:
General Adjustment:

PRE-WAR CIVILIAN ADJUSTMENT

ADJUSTMENT AFTER DISCHARGE FROM SERVICE

ADJUSTMENT AFTER LEAVING HOSPITAL

FAMILY HISTORY
Siblings:
Parents:
Education:
General Adjustment:

DRINKING HABITS PERSONALITY MAKE-UP

SEX PRACTICES MARITAL ADJUSTMENT

HOSPITALIZATION
History of Present Illness:
History of Previous Hospitalizations:
Present Hospital Adjustment:
Prognosis:

APPENDIX A

SCHEDULE USED

Name: Married Status: Diagnosis:

Status: Occupation: Admission Date:

Age: Total Hospitalization: Discharge Date:
Trial Visit " :

MILITARY HISTORY
Date Inducted:
Date Discharged:
Rank and Service:
General Adjustment:

PRE-WAR CIVILIAN ADJUSTMENT

ADJUSTMENT AFTER DISCHARGE FROM SERVICE

ADJUSTMENT AFTER LEAVING HOSPITAL

FAMILY HISTORY
Siblings:
Parents:
Education:
General Adjustment:

DRINKING HABITS PERSONALITY MAKE-UP

SEX PRACTICES MARITAL ADJUSTMENT

HOSPITALIZATION
History of Present Illness:
History of Previous Hospitalizations:
Present Hospital Adjustment:
Prognosis:

APPENDIX B

QUESTIONNAIRE USED

VETERANS ADMINISTRATION
Bedford, Massachusetts
December 10, 1945

Dear

The physicians under whose treatment you were while here, and our Social Service Staff, would like to hear what progress you have been making since you left, whether you have found work, or if not what you are doing. May we ask you to fill in the answers to the questions below and return this letter in the enclosed self-addressed envelope which will require no postage. If you wish to go into more detail than the space provided permits, please do so on the other side of this letter. We shall hope to hear from you soon and your courtesy will be appreciated.

Sincerely yours,

Manager

1. Are you living with parents or relatives?
2. Are you married, single or divorced? (Please underline one)
3. Are there any children?
4. If so, are they dependent on you for support?
5. Have you taken advantage of the G.I. Bill or any other government financed plan for further education or training since leaving this hospital?
6. If so, what have you studied or trained for? How long?
7. If not, will you give your reason for not doing this? (on back of letter)
8. Are you doing the same kind of work as before the war?
9. Are you working for the same employer?
10. If not, by whom and where are you employed?
11. What kind of work are you doing?
12. Are you earning more than before you enlisted?
13. How did you find your present job?
14. How do you like it?
15. Is it permanent or temporary?
16. If not working how do you spend your time?
17. How do you feel?

Your name and address

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Your name and address

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